



A SITUATION ANALYSIS OF ADOLESCENTS IN Thailand 2015–2016

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Executive summary

Thailand has demonstrated remarkable economic and social dynamism, moving from low-income to upper-middle income status as a country within the lifetime of a single generation. The fallout from two financial crises in 1997–1998 and 2008–2009 followed by the disastrous floods in 2011 caused setbacks to growth, and Thailand has been unable to recuperate its previous economic momentum. The impact of political tensions and uncertainty in 2010 and again in 2013–2015 further contributed to Thailand's lagging growth rates. Thailand's ageing population will also affect the country's ability to mobilize its economy and care for older persons.¹ Demographic change and modern lifestyles have led to a surge in non-communicable diseases and are responsible for 70% of all deaths among adults. The Thai labour force has shrunk by nearly 30%, causing the shortfall to be supplemented by migrant workers from neighbouring countries.

Of the 65.1 million people living in Thailand, approximately 8.7 million people are adolescents aged 10–19 years.² A sizable proportion of the adolescent population in Thailand is made up of documented and undocumented migrant workers.

Although the overall birth rate is decreasing, the adolescent birth rate is rising. In 2014, adolescent mothers were giving birth to approximately 320 babies per day – an important decrease from 360 babies per day in 2011.³ Pregnant adolescents face numerous barriers, including a high degree of social stigma and the potential risk of complications from clandestine abortions. An estimated 200,000–300,000 women of reproductive age seek abortions each year.⁴ The explosive increase in adolescent pregnancies partly stem from an increase in sexual relationships outside of marriage and because a small proportion of sexually active adolescents use contraception (a 2008 study found only a 16% use rate).⁵ Moreover, 70% of all sexually transmitted HIV infections in Thailand are occurring among young people aged 15–24 years. Despite a gradual drop in overall HIV prevalence over the past two decades, new infections are rising among young people from key populations, especially among young men who have sex with men.⁶

Access to basic education has increased over the past three decades. The vast majority of children attend school, with the net attendance rate in primary school at 93% in 2013, an increase from 80.4% in 2000 and 70.1% in 1990. The net attendance rate in secondary school, however, declined to around 80%, although this percentage does not account for the approximately 675,000 students aged 15–21 years registered in the vocational education and professional training system. Violence and militarization of the conflict in the three southern border provinces since 2004 are cause for the lowest school attendance rates (71.3%) in the South.⁷ Other challenges remain in terms of equal access to education and the quality of education, particularly for disadvantaged children and adolescents.

In Thailand, as in other countries, despite increases in access to education, rigid gender norms dictate appropriate roles and behaviours and contribute to the persistence of the gender inequalities. Recent data indicated that women are still less likely to participate in the labour force, are concentrated in certain sectors and earn less than men.⁸ For example, among youth aged 15–24, 56% of young men participated in the labour force, compared with only 40% of young women. And while young women were overrepresented among graduates in many fields, they made up less

1 IMF, 2015.

2 NESDB, 2014.

3 Bureau of Reproductive Health, 2015.

4 UNFPA, 2014.

5 NSO, 2009.

6 Herman, 2014.

7 National Statistical Office, et al., 2012.

8 Levkov, et al., 2014.



than 20% of graduates in the lucrative fields of engineering, manufacturing and construction.⁹ In addition to gender inequality, skills mismatch in the youth labour market has become a persistent and growing trend. Gender inequality manifests itself in other ways as well – in high rates of violence (31,866 women and children reported abuse and sought assistance from One-Stop Crisis Centres) and in low levels of women's political participation.¹⁰

Rigid gender norms do not only disadvantage women and girls, but in adhering to notions of idealized masculinity, men may engage in risky behaviours, such as unprotected sex, aggressive driving and violence.¹¹ Fatal road traffic injuries involving motorcycles account for the majority of deaths in adolescent boys each year. For many boys, excessive tobacco and alcohol consumption and gaming addictions are modelled on the behaviour of adult men as a way to prove virility and manhood. Boys make up the majority of the adolescent population in conflict with the law. Boys' educational underperformance in countries like Thailand has also been shown to be "the result of any underlying set of gender norms and socially determined, unspoken expectations concerning gender roles".¹² A 2016 review of sexuality education in Thai secondary schools and vocational colleges confirmed that problematic attitudes about sexuality and gender are still common among students; most teachers said they thought that sex between unmarried young people was unacceptable.¹³

The biggest challenge in creating a profile of Thai adolescents is the lack of data collected in a format that might be disaggregated by age, sex, and other variables such as immigration status, ethnicity, education, etc. In addition, the Thai adolescent population has not historically been surveyed as a population, with children younger than 15 years assessed in one study, and the remainder of the adolescents being grouped with 'adults' (ages 15–59 years). Sometimes, data may be reported for youth (aged 15–24) but with little consistency. More efforts from departments within multiple ministries are required to collect data on the 10- to 19-year-old age group because adolescence is a unique and prime target population for reform in development programmes. In terms of legal frameworks, the 2007 and the 2014 interim Constitution of Thailand were repealed in 2008 and 2015, respectively. Thailand is currently operating under another interim Constitution, and it is obvious that this volatility prevents cohesive administrative efforts to implement policy and ensure consistent enforcement.

The vision is for UNICEF and the Government of Thailand to build on and strengthen existing platforms that address the most important issues affecting adolescents aged 10–19 years: leveraging the power of regional networks, advocating for educational reform, supporting the National Strategy to Prevent Teenage Pregnancy, taking the lead on HIV prevention among young populations most at risk and promoting behaviours that prevent the onset of non-communicable diseases in adulthood.



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⁹ World Bank, 2013; World Bank, 2014.

¹⁰ *Bangkok Post*, 12 Dec. 2014; GenderStats, 2014.

¹¹ Levkov, 2014.

¹² UNGEI, 2012, p. 7.

¹³ Mahidol University, 2016.

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Abbreviations

ASEAN	Association of Southeast Asian Nations
CRC	Convention on the Rights of the Child
DCY	Department of Children and Youth
DMH	Department of Mental Health, MOPH
DOH	Department of Health, MOPH
GDP	gross domestic product
HITAP	Health Intervention and Technology Assessment Program
HTC	HIV testing and counselling
IHPP	International Health Policy Program
LBGTI	lesbian, gay, transgender, intersex
MICS	Multiple Indicators Cluster Survey
MOE	Ministry of Education
MOPH	Ministry of Public Health
MSM	men who have sex with men
NSO	National Statistical Office of Thailand
ONIE	Office of Non-formal and Informal Education
OPP	Office of Promotion and Protection of Children, Youth, the Elderly and Vulnerable Groups (renamed Department of Children and Youth in 2015)
OECD	Organisation for Economic Co-operation and Development
OVEC	Office of the Vocational Education Commission MICS
PISA	Programme for International Student Assessment
STI	sexually transmitted infections
TOEFL	Test of English as a Foreign Language
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Chapter 1. Introduction

Socio-political context of Thailand

Thailand comprises 76 provinces that are further divided into districts, subdistricts and villages. Bangkok, which is a special administrative zone, the capital city and centre of political, commercial, industrial and cultural activities, is also divided into districts and subdistricts. According to the national population register for 2014, Thailand's population of 65.1 million comprised 31.9 million males and 33.1 million females.¹⁴ Of them, an estimated 8.7 million were adolescents.¹⁵

The official religion of Thailand is Theravada Buddhism, a branch of Hinayana Buddhism, practised by more than 93.6% of the population. The remainder of the population adheres to Islam (4.9%), Christianity (1.2%), other faiths (0.2%) or no faith (0.1%), all of which are allowed freedom of expression.¹⁶ Despite wide-ranging religious freedom, Thai cultural constructs emphasize the notion of male superiority in politics and religion. Buddhist ideology has been manipulated through male hegemony to oppress women via cultural and moral patterns.¹⁷ Thai women may become nuns, but they may not be ordained as monks. The monkhood is reserved for men only. Many Thai women are convinced that they were born female due to their bad karma, so they engage in merit making to improve their karma for a future incarnation.¹⁸

Despite a period of political volatility beginning in 1970, Thailand has demonstrated remarkable economic and social dynamism, moving from low-income to upper-middle income status as a country within the lifetime of a single generation. Thailand's rapid economic growth, as much as 8–9% per year during the late 1980s and early 1990s, was interrupted by the Asian financial crisis of 1997–1998. Since then, economic growth has been steady but moderate, with a peak growth period of 5% between 2002 and 2007. The fallout from the global financial crisis of 2008–2009, followed by the disastrous floods in 2011, caused setbacks to growth, and Thailand has been unable to return to its previous economic momentum. The impact of political tensions and uncertainty in 2010 and again in 2013–2015 have further contributed to Thailand's lagging growth rates and situated it more firmly among neighbouring low and middle-income East Asian countries in recent years. Thailand's growth was 0.7% in 2014, but it was projected to rebound to 3.7% in 2015.¹⁹

Thailand's rapidly ageing population will also affect the country's ability to mobilize its economy.²⁰ Birth rates are decreasing overall, except for the adolescent pregnancy rate. Even considering the downward trend between 2012 and 2014, the adolescent pregnancy rate is currently 47.9 births per 1,000 young women aged 15–19 years. Also presenting obstacles to economic growth, the Thai labour force has decreased by nearly 30% in recent years. Additionally, a general trend observed in Thai society is the decrease in the average family size and deterioration of self-sufficient community-level governance. Changing cultural traditions like these are likely symptoms of increasingly multicultural neighbourhoods.²¹

Thailand will face a multitude of barriers to growth in the coming generation due to demographic shifts. With a rapidly ageing population and plunging birth rates, the dependency ratio is expected to hit a trough in 2015 and then start rising swiftly. With nearly 40% of the labour force employed in low-productivity agriculture, the reallocation of resources to higher value-added sectors appears to have stalled.

A significant share of Thailand's export capacity is in electronics, and many of its primary products are facing low global demand growth (hard disk drives, fax machines, digital cameras). While Thailand's ranking in overall global competitiveness is strong (31 of 144), it ranks much lower on innovation, technological readiness and quality of education.

Violence in the far South is one of the factors in Thailand's unsteady growth. With frequent outbreaks of violence affecting children, teachers and other education personnel, intermittent closure of schools in the region is increasingly common.²²

14 สำนักงานสถิติแห่งชาติ กระทรวงเทคโนโลยีสารสนเทศและการสื่อสาร (2558) ตัวชี้วัดสำคัญของประเทศไทย พ.ศ. 2558.

15 NESDB, 2014

16 NSO, 2010.

17 Archavanitkul, 2011.

18 Fongkaew, 2005.

19 IMF, 2015.

20 ibid.

21 NESDB, 2015.

22 Bureau of International Labour Affairs, 2015.

Adolescents

Adolescence is defined as the period of transition from childhood to adulthood, during which young people go through many physical, emotional, intellectual and social changes. 'Adolescent development and well-being' is a comprehensive construct useful in assessing an individual's ability to acquire knowledge, skills, experience, values, and social relationships as well as access to basic services. Institutions and policies that promote or enable adolescent development and well-being are those that prepare individuals to negotiate multiple life domains, participate in community and civic affairs, earn income, avoid harmful and risky behaviour and able to thrive in a variety of circumstances, free from preventable illness, exploitation, abuse and discrimination. This construct also evaluates the ability of the surrounding society (family, peers, community, social institutions) to support those aspects of well-being.²³

Adolescent development and well-being depends on the full realization of rights outlined in the Convention on the Rights of the Child (CRC), adopted by Thailand in 1989, to protection and support related to family and other social institutions, health, employment, juvenile justice, religion, culture and identity.

Government institutions, communities, families and other duty bearers have an obligation to support adolescents and to ensure that they have the opportunities and capacities to transition from childhood to adulthood successfully. Increased support is needed in many domains.

The rapid biological and psychosocial changes that take place during adolescence make this a uniquely important period in the life course of an individual. It is an important time for laying the foundations for good health in adulthood.

Changes in adolescent lifestyles have the potential to affect a wide spectrum of diseases and health-related behaviours in adulthood. Positive interventions in the second decade of a person's life can allow for the epidemiological transition from infectious disease status to non-communicable conditions. At the same time, untreated health problems and behaviours that arise during adolescence – chronic illnesses and alcohol use, for example – affect physical and cognitive development irrevocably.²⁴ This critical period of cognitive development and personal awareness in adolescence can greatly affect an individual's views of health and personal goal-setting capabilities. The primacy of adolescence as a stage for intervention should inform both the planning and implementation of programmes in Thailand.

The definitions of 'child', 'adolescent' and 'youth' vary greatly from agency to agency in Thailand. The National Child and Youth Development Promotion Act 2007 defines a child as a person younger than 18 years and youth as a person aged between 18 and 25 years.²⁵ The Act of Juvenile and Family Court and Procedure or Juvenile and Family Cases 2010 specifies that child means a person who is not yet exceeding 15 years in age and young person means a person who is between 15 and 18 years of age.²⁶ The Ministry of Public Health has a more overlapping definitional approach, using child to describe people aged 0–18, adolescents as people aged 10–19 and youth as people aged 15–25.²⁷

This analysis uses the United Nations definitions of children, adolescents and youth:

Adolescents: aged 10–19 years.

Children: aged 0–17 years.

Youth: aged 15–24 years.

Young people: aged 10–24 years.

Because the collection and disaggregation of data by age conform to the traditional norms of child (0–14 years)²⁸ and working-age population (15–59 years), data disaggregated for children (0–18 years, or 6–15 years) and youth (15–24 years) are also used.



²³ UNICEF, 2005.

²⁴ McNeely and Blanchard, 2009.

²⁵ สำนักงานส่งเสริมสวัสดิภาพและพิทักษ์เด็ก เยาวชน ผู้สูงอายุ (สท.) กระทรวงการพัฒนาสังคมและความมั่นคงของมนุษย์ (2550) พระราชบัญญัติ ส่งเสริมการพัฒนาเด็กและเยาวชนแห่งชาติ พ.ศ. ๒๕๕๐

²⁶ กรมพินิจและคุ้มครองเด็กและเยาวชน (2557) รายงานสถิติคดี ประจำปี พ.ศ. ๒๕๕๗

²⁷ Child, age 0 up to but not including their 18th birthday. Adolescent, age 10 up to but not including their 15th birthday, and youth, age 15 up to but not including their 25th birthday.

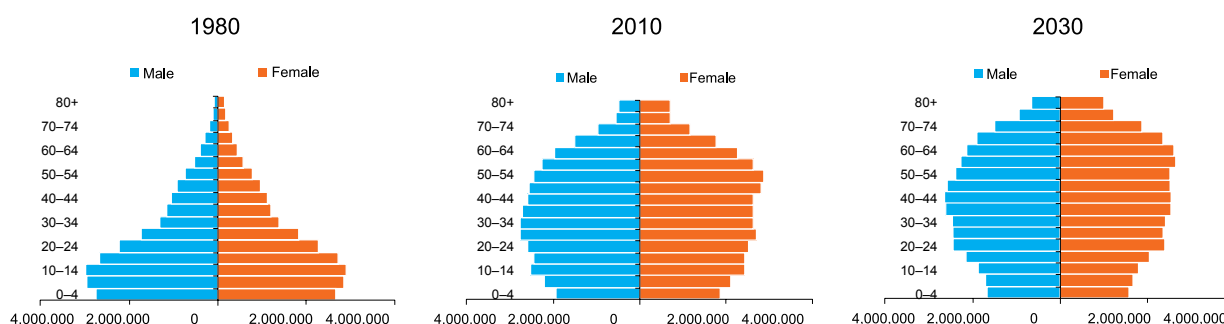
²⁸ Up to but not including their 15th birthday.

Demographic profile

Thailand has become a rapidly ageing society. The situation has changed due to a decline in the birth rate, with families tending to have fewer children because of declining infant mortality, easier access to family planning services and lifestyle changes. The population size is not expected to change over the next two decades, but changes will occur in its age structure and geographic distribution.²⁹

Rapid growth will occur in the population aged 65 and older. The population aged 30–64 years will continue to grow for a time but then level off. The age groups of 15–29 and 0–14 years are already shrinking. The following pyramids (see Figure 1) show great changes in the population of 2010 and the projected population for 2030.

Figure 1. Population pyramids, 1980, 2010 and 2030



Source: UNFPA, 2009. Calculated from United Nations Population Division, 2009, low projection.

The share of the working-age population in the total population began to decline in 2015. For the past 40 years, the share of the working-age population steadily rose, creating a favourable situation for rapid economic development.

Ageing in Thailand will be rapid over the next 20 years, when the proportion of the population aged 65 and older is expected to double. This has implications for family structure, for the care of dependant older family members, for income maintenance of older persons and for the dynamism of Thailand's economy.³⁰

The contraction in workforce entrants puts pressure on Thailand to ensure that productivity is enhanced. Although lower- and upper-secondary school enrolment rates expanded rapidly over the past two decades, the quality of education still leaves something to be desired. It is crucial for Thailand's continued development that young people entering the workforce are equipped with the knowledge and skills needed to meet the labour market needs of a Thai economy with continuous growth.

A smaller number of people in the working-age group will mean smaller contributions to the country's productive capacity and tax revenue base. It is also likely that the burden of care within households will fall on the shoulders of women who function as family service providers. Meanwhile, the Government will need to spend more on health care and social assistance to combat poverty among older persons. The decline in the working-age population may also have implications for the demand for foreign workers to fill the labour gap.³¹

Adolescent population

The estimated 8.7 million adolescents in Thailand amounts to 13.3% of the total population.³² Bangkok has the largest number of adolescents (at more than 700,000), followed by Nakorn Ratchasima (at 300,000) and Ubol Ratchathani (at 250,000) (see Figure 2).

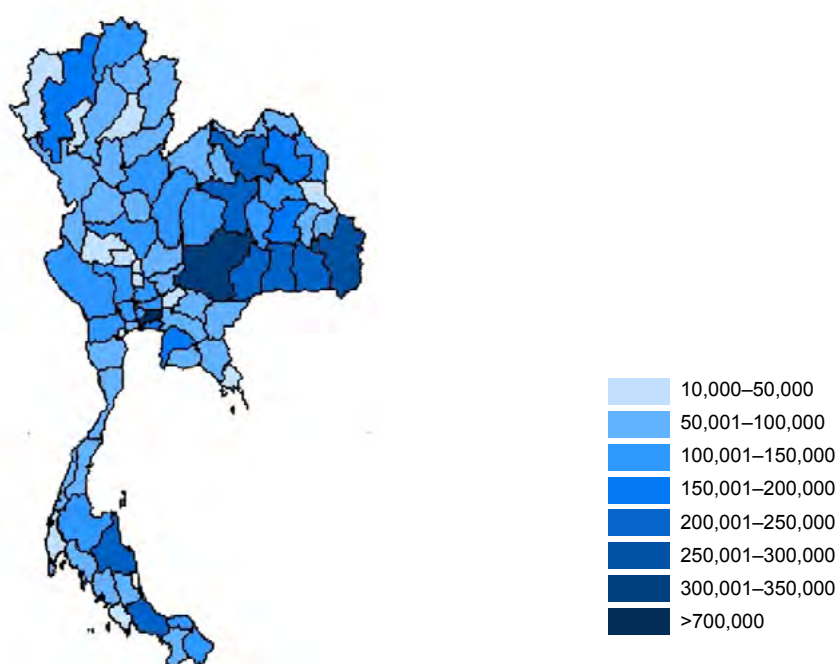
²⁹ UNFPA, 2009.

³⁰ UNFPA, 2009.

³¹ UNICEF, 2011.

³² NESDB, 2014.

Figure 2. Thailand's adolescents aged 10–19 years, by province



Source: Ministry of Interior housing registration data.

Adolescent migrants

Evidence from the 1990s indicated that adolescents then were extremely mobile, migrating to both rural and urban destinations for work and school reasons. One interesting aspect of this mobility was the frequent and circular movement of Thai adolescents between rural and urban settings. At that time, adolescents aged 15–19 years represented the largest proportion of rural – urban migrants.³³ They migrated independently or with their families and, in many cases, confronted difficult life choices with employment, education and health. There were also gender-based differences in that adolescent migration. For instance, while girls and boys were equally represented in the migrant streams, their experiences were anecdotally understood to be profoundly different. This migration took the form of frequent moves between the home and various destinations. It was a dynamic form that meant that adolescents were frequently moving between two worlds: one modern and one traditional.³⁴

The actual number of foreign nationals living in the country is unknown. The most recent estimate was 3.7 million foreign nationals living here in 2013. The estimated number of workers from Cambodia, the Lao People's Democratic Republic and Myanmar was 2.7 million; among them, 1.1 million had a work permit and 1.6 million had irregular status.³⁵ The Department of Labour Protection and Welfare estimated in 2011 that there were around 510,000 migrants aged 15–18 years with a work permit.³⁶ However, there is no estimate for unregistered adolescents, who work in 'hidden' or marginal jobs to an even greater extent than adults.

Married adolescents³⁷

Thai law sets the minimum age for marrying at 17 years. Written parental consent is required for anyone younger than 20 years who wants to marry. The law applies to both boys and girls, but the practice overwhelmingly affects girls. The 2010 National Population and Housing Census showed that 13.3% of girls aged 15–19 were either married or living with a sexual partner. This was consistent with data from the fourth Multiple Indicators Cluster Surveys (MICS) conducted by the National Statistical Office in 2012. In the MICS 4, 22.1% of women aged 20–24 reported they had been married or had lived with their sexual partner before the age of 18, an increase of 2 percentage points from the MICS 3.³⁸ The highest rates of marriage or sexual partnership among 15- to 19-year-olds was found in six provinces – Chai Nat, Prachuap Khiri Khan, Phang Nga, Rayong, Samut Sakhon and Uthai Thani. Three of those six provinces also recorded the lowest levels of education among women.³⁹

³³ Chamratrithirong, et al., 1995.

³⁴ Soonthornthada, et al., 2005.

³⁵ National AIDS Committee, 2015.

³⁶ UN Thematic Working Group on Migration in Thailand, 2014.

³⁷ UNFPA, 2013.

³⁸ UNFPA, 2014.

³⁹ *ibid.*

Chapter 2. National policy framework

Legal context

The 1997 Constitution of Thailand, often called the 'people's Constitution', is considered by many human rights activists and scholars as a landmark in terms of public participation for the drafting of its content. Many human rights were acknowledged for the first time, and a bicameral elected legislature was established. This Constitution was abrogated by the 2006 military coup and replaced by the 2006 interim Constitution. The army-led Council for National Security appointed a group of scholars to draft a new Constitution, which was later approved by a public referendum in 2007. Following the May 2014 coup d'état by a military junta, the 2007 Constitution was repealed. In July 2014, the military junta, via the National Council for Peace and Order, promulgated an interim Constitution drafted by scholars.⁴⁰

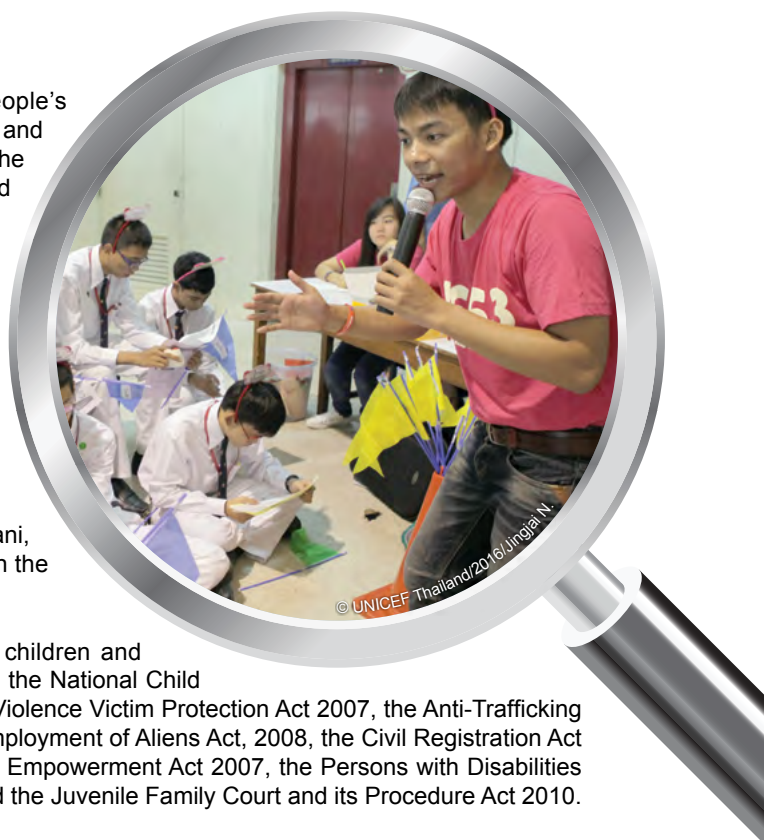
Martial law remains in place in the southern provinces of Pattani, Yala and Narathiwat and has had multiple adverse effects on the well-being of children and adolescents.

Multiple laws drafted to protect the liberties and rights of children and adolescents were enacted in 2007 and 2008⁴¹ among them: the National Child and Youth Development Promotion Act 2007, the Domestic Violence Victim Protection Act 2007, the Anti-Trafficking in Persons Act 2008, the Labour Protection Act 2008, the Employment of Aliens Act, 2008, the Civil Registration Act 2008, the Nationality Act 2008, the Persons with Disabilities Empowerment Act 2007, the Persons with Disabilities Education Act, 2008, the Child Adoption Act (No. 3) 2010 and the Juvenile Family Court and its Procedure Act 2010.

Children and Youth Development Act 2007

Responsibility for formulating and coordinating youth policy now lies within the Department of Children and Youth (DCY) within the Ministry of Social Development and Human Security, which has experienced multiple challenges in coordinating the efforts of different ministries and agencies involved in child and adolescent issues.

The Children and Youth Development Act 2007 seeks to strengthen institutions addressing the challenges to children's and adolescent's development. The Act follows the principles and concepts of the Convention on the Rights of the Child, which Thailand ratified in 1992, principally, to act in accordance with 'the best interests of the child'. It reaffirms the right to basic education of good quality stipulated in the 2007 Constitution. Children with disabilities and those with differing learning abilities are entitled to government-provided special education. It also reaffirms children's right to the highest available standard of health care and the rights to play and to participate in cultural and social life. Article 7 of the Act stipulates that all children are entitled to have their birth registered and to exercise their right to development, protection and participation without discrimination (see Annex IV for an overview of the laws applicable to Thai adolescents).



⁴⁰ "Article 44 of the interim Constitution gives the head of the NCPO unfettered power to give any order deemed necessary for "...the benefit of reform in any field and to strengthen public unity and harmony, or for the prevention, disruption or suppression of any act which undermines public peace and order or national security, the Monarchy, national economics or administration of State affairs." Article 47 provides that all National Council for Peace and Order announcements and orders given since the coup and up until the National Council of Ministers takes office "...regardless of their legislative, executive or judicial force..." are also "... deemed to be legal, constitutional and conclusive"; and Article 48 states that all those carrying out acts under orders of the National Council for Peace and Order in relation to the coup, even if the acts are illegal, "...shall be exempted from being offenders and shall be exempted from all accountabilities." The International Commission of Jurists' submission to the UN Committee on Economic, Social and Cultural Rights in advance of the examination of Thailand's initial and second periodic reports under articles 16 and 17 of the international covenant on economic, social and cultural rights, 11 May 2015, para 8.

⁴¹ List provided by Sommanat Juaseekoon, Recent Developments of Legal System in Thailand, ASEAN Law Association, 10th General Assembly, quoting Ministry of Foreign Affairs, Thailand's contributions, commitments and voluntary pledges to the promotion and protection of human rights: Election to the Human Rights Council for the term 2010–2013.

National Children and Youth Development plan

While the National Economic and Social Development Plan sets out the overall development priorities for the country, the national priorities for children and young people are set in the National Children and Youth Development Plan. Based on the 2007 Child and Youth Development Promotion Act, the National Child and Youth Development Plan 2012–2016 was developed under the leadership of the Ministry of Social Development and Human Security. The Plan is meant to integrate and consolidate efforts for children and adolescents at all levels, supporting them to “lead a secured life, to ensure their physical and mental well-being; to encourage moral, ethical and civic awareness; to encourage them to express themselves creatively and without inhibitions in accordance with a democratic way of life”. In terms of governance, the National Child and Youth Development Plan has postulated a rather complex and intersectoral structure for the coordination of its implementation (see *Figure 3*).

Figure 3. Cross-sectoral committees under the Child Protection Act

National Commission on the Promotion of Children and Youth Development (chaired by the PM)	
Comprised of: 1. Prime Minister or Deputy Prime Minister designated by Prime Minister as the Chairperson 2. Minister, MSDSH, the First Vice Chairperson 3. Minister, MoE, the Second Vice Chairperson 4. PS, Minister of Defense 5. PS, Minister of Tourism and Sports 6. PS, MSDSH 7. PS, Minister of Interior 8. PS, Minister of Justice 9. PS, Minister of Labour 10. PS, Minister of Culture 11. PS, Minister of Education 12. PS, Minister of Public Health 13. The President of National Council for Child and Youth Development under the Royal Patronage of H.R.H. Princess Maha Chakri Sirindhorn 14. Two representatives, Child and Youth	12 Sub – Committees (appointed as of June 2015) 1. Early childhood development 2. CRC 3. Policy and plan on child and youth development 4. Revision of laws related to children (Majestic Gr) 5. Annual report on child and youth development 6. Capacity development of persons working on children and youth issues 7. Prevention and addressing IDD in children and youth 8. Prevention and suppression teenage pregnancy 9. Promotion of child and youth council's activities 10. Advisory group for management of Children and Youth Council in Thailand 11. Promotion of Thai traditional music activities 12. Ad-hoc committee for coordination and Preparation of VAC policy and plan in ASEAN

Adolescent participation and civic engagement

In Thailand, not much attention is paid to adolescents' decision-making in the family. However, adolescent participation at the community level has been promoted in the form of Child and Youth Councils. An important requirement of the Children and Youth Development Act is the establishment of national and local mechanisms to promote the participation of children and young people at all levels.⁴² The Department of Children and Youth (formerly the Office of Promotion and Protection of Children, Youth, the Elderly and Vulnerable Groups) started setting up Child and Youth Councils at the district and provincial levels in 2008. As of December 2013, there was a total of one National council, one Bangkok-based council, 76 provincial councils and 878 district councils. The budget for the establishment and maintenance of the Child and Youth Councils is allocated through the DCY, although it is insufficient to support all planned activities and lacks independent financial management. To apply for government funds, councils need to solicit approval from the district, provincial or national level. This has led several councils engage in their own fundraising activities. The National Children and Youth Council was formed in June 2009 and includes representatives from provincial councils and 38 representatives from youth groups.

“I have heard of the Child and Youth Council, but I do not know what it does. I also do not know who represents the youth in this community.” – Out-of-school female adolescent

A recent study found that an overwhelming proportion of youth council members (91.7%) had insufficient knowledge about the management and functioning of the Child and Youth Councils as specified by the law.⁴³ The study looked at knowledge about the structure, roles and responsibilities of the councils and mission and the links between the councils at different levels. The conclusion was that adolescents feel they have no decision-making power in their communities. Programmes and activities have been designed for them, but they have never been invited to be involved in these activities.

⁴² UNFPA, 2015.

⁴³ Pornwalai, 2013.

“Every year there are activities to clean up the community but we are never invited to help organize these activities. To the adults, our participation means picking up garbage only.” – Out-of-school female adolescent

There has been limited participation of young people who are out of school in the councils, especially at the management level. Younger children are also underrepresented, largely because they are viewed as less capable than older children. The involvement of young female leaders, particularly at the national level, needs to be encouraged and closely monitored.

In addition to the National Youth Council, grass-roots youth groups include the Education for the Liberation of Siam, which is an organization run by high school students who advocate for reform of the Thai education system.⁴⁴ Another grass-roots group is the Young Citizen Reporter, which focuses on environmental issues.⁴⁵ The private sector is also supporting youth to speak out, such as the Dtac Youth Forum.⁴⁶

Bottlenecks and barriers

The main bottlenecks with regards to the enabling environment are:

Weak institutional coordination: Thailand is currently operating under an interim Constitution that was drafted without public consultation; collaborative planning, budgeting and joint results between and within ministries are limited and prevent cohesive administrative efforts from ensuring consistent implementation and enforcement of policies. Roles and responsibilities within the Government are not clear.

Insufficient resources (both funds and capacities) of the Ministry of Social Development and Human Security: The Department of Children and Youth is responsible for formulating and coordinating youth policy across government ministries and agencies. The Department is underfunded and lacks the authority to efficiently coordinate. It operates within a complex institutional framework, which makes it essentially ineffectual, at least when compared with more powerful ministries and agencies.

Tokenistic and unequitable youth participation opportunities due to social norms that consider adolescents as immature: Even though Thailand has established structures for youth civic engagement at the national, provincial and district levels, children and youth participation is underfunded, tokenistic and elitist. The most influential youth leaders are overwhelmingly male and in the upper range of the age spectrum. Youth council members are not involved in planning and decision-making. Younger children, out-of-school youth and women are marginalized and do not have opportunities to participate. Intergenerational power differentials pose yet another challenge to youth involvement.



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⁴⁴ See www.elsiam.org.

⁴⁵ See www.citizenthaipbs.net.

⁴⁶ See www.dtac.co.th/telenoryouthforum-2015.html.

Chapter 3. Formal and non-formal education

Access to formal education

Access to basic education has increased in the past three decades. The vast majority of children attend school, with the net attendance rate in primary schools at 93% in 2013, an increase from 80.4% in 2000, and 70.1% in 1990. The net attendance rate in secondary schools, however, had declined to around 80%. The southern provinces had the lowest rate (at 71.3%) among all regions.⁴⁷ A positive correlation with mother's education was reported for school attendance. The proportion of students attending secondary school or higher whose mothers had a post-secondary school education was 94.3%, compared with only 59.1% of children whose mothers had no education.⁴⁸ Rural adolescents were twice as likely to enrol in primary school and not secondary school because they had started school late, and 34% of adolescents in school at age 12 (at the beginning of the school year) were still attending primary school.⁴⁹ Rural adolescent girls were more likely to enrol in school late than boys.

In terms of gender parity, there was virtually no difference in the attendance rates at pre-school and primary school. At secondary school, however, more girls attended lower secondary school than boys in both the urban (74% and 68%, respectively) and rural areas (79% and 66%, respectively).⁵⁰

Rigid gender norms not only disadvantage women and girls, but in adhering to notions of idealized masculinity, men may engage in risky behaviours, such as unprotected sex, aggressive driving and violence.⁵¹ Boys' educational underperformance in countries like Thailand has been shown to be "the result of any underlying set of gender norms and socially determined, unspoken expectations concerning gender roles".⁵²

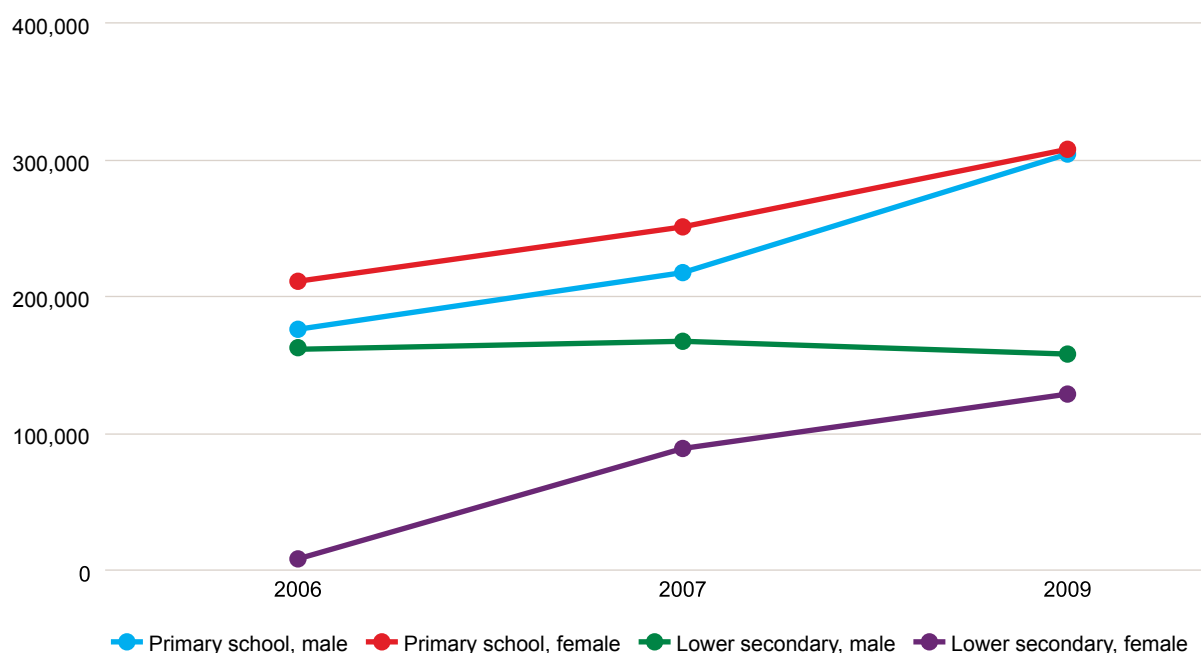
"Since education systems are embedded in the broader social context, they reflect the inequalities that exist in society."⁵³ The structure and content of schooling – textbooks, curricular choices, sex distribution of teachers and administrators, teachers' attitudes and behaviours, classroom and discipline practices and the presence of violence – reflect discriminatory and harmful social norms about the appropriate roles and opportunities for boys and girls.⁵⁴ At the same time, schools have enormous potential to effect social change and transform gender relations, expanding the range of possibilities for both boys and girls.⁵⁵

Challenges remain in terms of equal access to education, particularly for disadvantaged children. This includes ethnic minority children, those living in rural and remote areas, children with disabilities, children affected by HIV, refugees and stateless and migrant children. An estimated 250,000 children were out of school in 2009 (see Figure 4).⁵⁶ The Government has adopted several education policies aimed at reaching traditionally marginalized and excluded groups.



47 NSO, et al., 2012.
48 ibid.
49 UNICEF website, 2015
50 ibid.
51 Levto, 2014.
52 UNGEI, 2012, p. 7.
53 Levto, 2014.
54 Connell, 1996, 2000 and 2010.
55 UNGEI, 2012.
56 UNESCO UIS 2015.

Figure 4. Trends in the number of out-of-school children in Thailand, 2006–2009



There are some efforts in schools to accommodate children with disabilities. But the majority of physically and mentally disabled children and adolescents remain ‘invisible’ and outside the school system due to Buddhist teachings linking disabilities with sins committed in a previous life, and thus which many families experience as shameful.⁵⁷ Special schools catering to children and adolescents with disabilities are rare. A survey of 353 schools in 2007 found that around 7% of students had learning disabilities (7.1% for reading, 6.8% for writing and 6.6% for mathematics). Male students were three to four times more likely to have learning disabilities, compared with female students.⁵⁸ Another study found that 44% of juvenile offenders had learning disabilities, which may partly explain the elevated school drop-out rates and the failure of rehabilitation programmes for this group.⁵⁹ Learning disabilities not only affect educational outcomes but also social outcomes. Individuals with learning disorders may be stigmatized and bullied by students and teachers, which can lead to low self-esteem and other mental health problems.⁶⁰

Despite estimates that the total number of school-aged children and adolescents with a range of disabilities is significant, existing data collection mechanisms exclude this group. One in-depth study revealed that there were approximately 3,000 children with disabilities in one district alone.⁶¹ It is difficult to determine the number of excluded children and adolescents, given the lack of information systems that focus on them. This is especially true for migrant children (both external and internal) and displaced young persons frequently on the go.

UNICEF is working with the Ministry of Education on a system to track out-of-school children across the country. The system is being piloted in 25 provinces, and educators have been trained to ensure that the data gathered on out-of-school children is used to get more children into school.⁶²

Quality education

The quality of education that children receive in Thailand is a major concern. Studies have shown that the learning level of Thai children in major subject areas has declined over the past ten years. The quality of the Thai primary education system is ranked 89th of 140 countries in the Global Competitiveness Index. The quality of math and science education at secondary and tertiary level is ranked 79th of 140 countries.⁶³ In recent years, results of the National Achievement Test have been dismal, with average scores for Grade 6 and Grade 12 students in core subjects at less than 50 per cent.⁶⁴

⁵⁷ Hill and Sukpunpant, 2013 and Thongkuay.

⁵⁸ HITAP, 2011, see www.hitap.net/en/research/17663 <accessed 24 Nov. 2015>.

⁵⁹ Faculty of Medicine, Ramathibodi Hospital, ‘Learning disorders’, <<http://med.mahidol.ac.th/ramamental/generaldoctor/09042014-1230>> accessed 24 Nov. 2015>.

⁶⁰ *ibid.*

⁶¹ NSO, 2012.

⁶² UNICEF website, 2015.

⁶³ World Economic Forum, 2015.

⁶⁴ UNICEF Thailand website

An important goal of the Education for All policy is to ensure continuous improvement in the quality of education for children and adolescents. The Government has invested 25% of its national budget in education, particularly in an education reform plan that has been taking place for many years. However, several assessments of the quality of education have not demonstrated satisfactory outcomes. It is thought that inefficiencies within education system financing, lack of qualified teachers in rural areas and huge disparities in the quality of teaching between urban and rural areas are some of the causes for the poor outcomes.

Among the 65 countries participating in the Programme for International Student Assessment (PISA) in 2012, students in Thailand ranked 48th in reading and science and 50th in mathematics. In the PISA reading assessment, one third of the Thai 15-year-olds knew the alphabet and could read but were unable to locate information and/or identify the main messages in a text, thus rendering them functionally illiterate. Functional literacy is an important indicator of whether students possess critical skills for a skilled job. In contrast, the average score for students in lower-income Viet Nam was 66 points higher than the average score for Thai students, which implies that, on average, a 15-year-old in Viet Nam is approximately 1.5 academic years ahead of the average Thai student.⁶⁵

In terms of command of the English language, Thailand had the lowest average TOEFL score (74 of 120) in 2014 among Association for South-East Asian Nation members. Thailand ranked 48 of 63 participating countries in the English Proficiency Index and was classed in the 'very low proficiency' group.⁶⁶ Thailand scored poorly despite relatively high internet availability in schools (with a rank of 54 of 140) and good staff training (with a rank of 41 of 140) in the World Competitiveness Survey.⁶⁷

Results from the Ordinary National Education Test have demonstrated consistently poor educational performance for Thai students over the past several years. Of a maximum score of 100, Thai students scored an average of 44.8 points in Grade 6 and 31.45 points in Grade 12, and neither score reflected an improvement from the level in 2011. The average scores of Grade 6 students were less than 50 points in six out of eight subjects and in seven out of eight subjects in Grade 12. In the assessment of the Thai language, the average score was only 45.02 points. Students from poorer families and those with disabilities scored far worse than the average.⁶⁸

The V-NET test conducted among graduating vocational students in 2012 also revealed poor performance in all three areas (30.96 in applied fundamental subjects, 31.66 in learning subjects and 33.1 in vocational subjects). The 2013 results showed some improvement in applied fundamental subjects (39.27). No data were available for the other two subject areas.⁶⁹

These examples confirm that education quality has been difficult to change. The average scores of Thai students on standardized performance tests have remained stable, despite huge investments in education reform.

School drop-out rates

In the period from 2009 to 2012, the school drop-out rate declined rapidly due to the provision of basic education at no cost to students.⁷⁰ The school drop-out rate nominally increased in 2013, but it is still less than 1% at all three levels of education (see Figure 5).

Parents moving out of the area, family problems, poverty and adjustment issues are some of the reasons for students dropping out of school. Early marriage and unwanted pregnancy are the main reasons for dropping out among adolescent girls.⁷¹ Low family income is also associated with school drop-outs. Adolescents from families with an annual income of less than US\$1,200 per month (around 42,000 baht) are more likely to drop out before the end of secondary school than adolescents from higher-income households.⁷²

Students who drop out of the formal school system usually register with one of the many non-formal education centres nationwide. In the 2013–2014 school year, registration at the Office of Non-formal and Informal Education centres increased by 200,000 students, the majority of whom were drop-outs from the formal education system.⁷³

65 World Bank, 2015.

66 ETS, 2015.

67 World Economic Forum, 2015.

68 NIETS, 2014.

69 *ibid.*

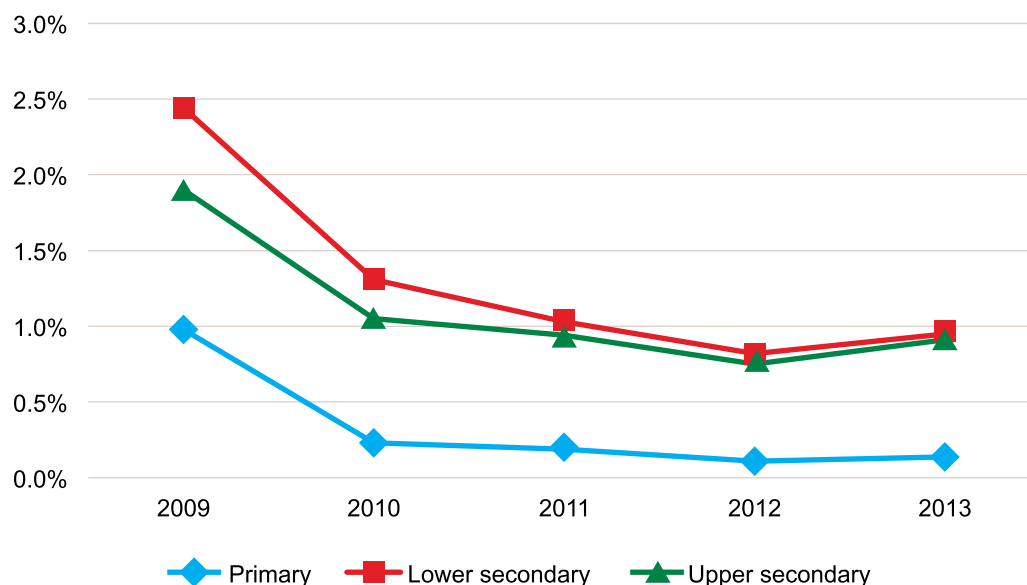
70 MOE, 2015.

71 OPP, 2013.

72 MOE, 2015.

73 OPP, 2014.

Figure 5. Drop-out rate for primary, lower secondary and upper secondary school, 2009–2013 (percentages)

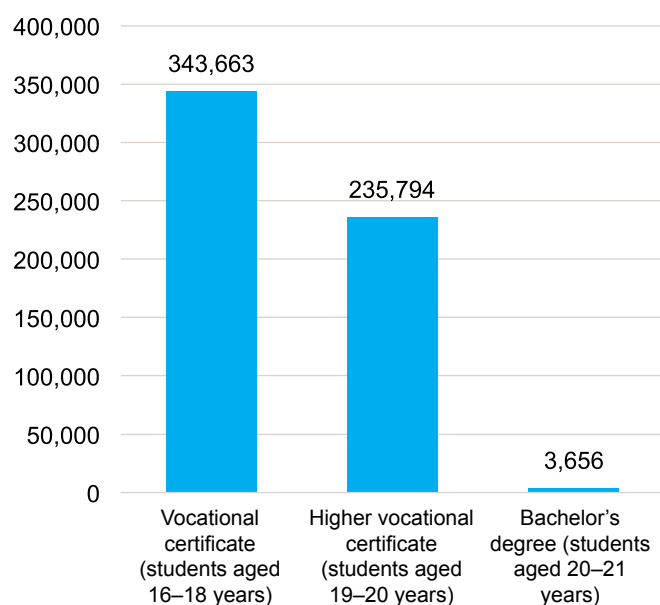


Source: Office of the Permanent Secretary, Ministry of Education, 2009–2013.

Adolescents in vocational training

The Office of the Vocational Education Commission (OVEC) under the Ministry of Education oversees vocational education and professional training in 426 public schools and 484 private schools⁷⁴ across the country. Education and training is structured along three levels: the vocational certificate, the higher vocational certificate and the bachelor's degree. In 2015, there were 674,113 male and female students aged 16–21 years in the vocational education system.

Figure 6. Adolescents in the vocational education system, 2015



⁷⁴ See www.vec.go.th/สถานศึกษาในสังกัดสอศ/สถานศึกษาอาชีวศึกษาวิทยาลัย.aspx and www.vec.go.th/สถานศึกษาในสังกัดสอศ/สถานศึกษาอาชีวศึกษาเอกชน.aspx.

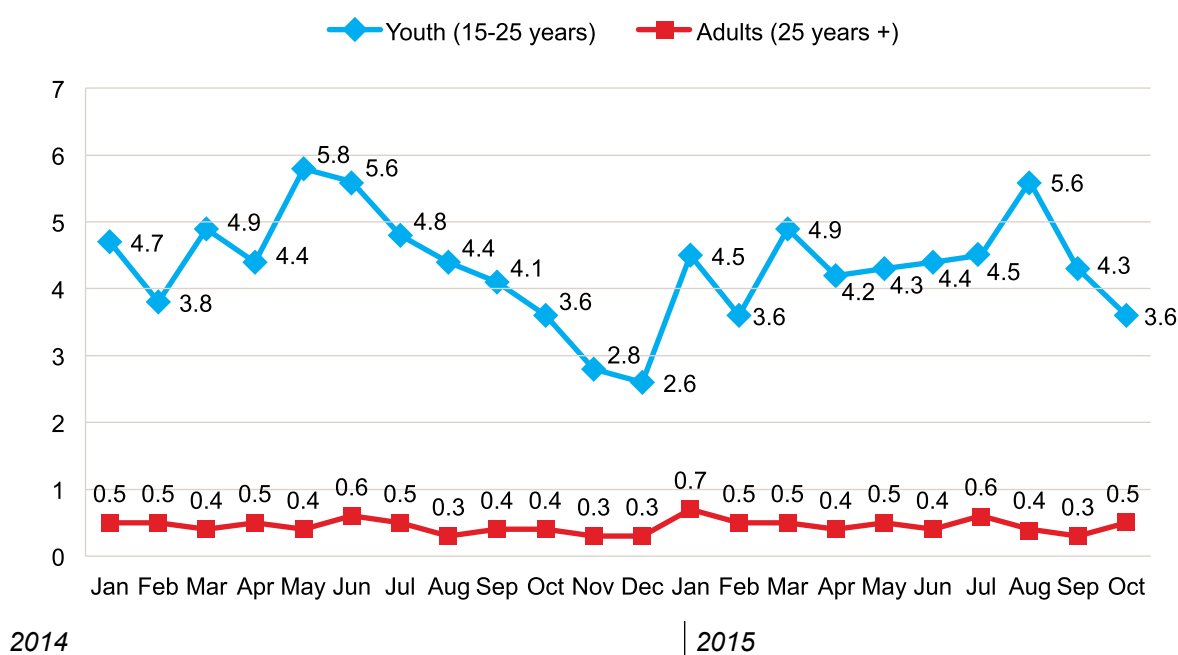
Students in the vocational education system have received negative reviews in the press due to multiple outbreaks of violence among them. In 2012 alone, the Deputy Commissioner of the Bangkok Metropolitan Police recorded 1,222 cases of student violence in Bangkok and its suburbs – a rate of approximately 100 cases per month.⁷⁵ Although there is no evidence to indicate that the level of violence among vocational school students is higher than for other groups of adolescents, violence among students in the vocational education system is frequent and has a great impact on their daily life. Research conducted in a province near Bangkok revealed that vocational students do not feel safe commuting to and from school because they are afraid of being targeted by rival school factions.⁷⁶ Many students avoid using public transportation and spending time in public spaces, like shopping centres, to avoid clashes with students from rival schools. Motorcycles are the most common mode of transportation to get to and from school.

Dropping out of school due to violence and other factors is of great concern. In a recent poll of 1,018 students, 73.4% of them said that they had friends who dropped out of vocational school. And 88.5% of those who dropped out cited personal problems as the main reason.⁷⁷ The OVEC is looking in to strategies to reduce the drop-out rate to less than 5%. The student drop-out rate has already declined, from 21% in 2011 to 10% in 2013. Despite the success, the drop-out rate for vocational school is ten-times higher than the rate for the basic education system.

Skills mismatch

The unemployment rate for youths (aged 15–24 years) was 4.3% in September 2015, compared with the adult unemployment rate (older than 25 years) at 0.3% (see Figure 7).

Figure 7. Comparison of unemployment, by age group, 2014 and 2015



Source: National Statistical Office, see http://web.nso.go.th/en/survey/data_survey/191058_summary_September58.pdf <accessed 8 Nov. 2015>.

In Thailand, as in other countries and despite increases in access to education, rigid gender norms dictate appropriate roles and behaviours and contribute to the persistence of the gender-based inequalities. Recent data indicate that women are still less likely to participate in the labour force, are concentrated in particular sectors and earn less than men.⁷⁸ For example, among youth aged 15–24 years, 56% of the young men participated in the labour force, compared with only 40% of the young women, and while young women were overrepresented among graduates in many fields, they made up less than 20% of the graduates in the lucrative fields of engineering, manufacturing and construction.⁷⁹

⁷⁵ See www.aljazeera.com/indepth/features/2013/02/20132109331225548.html.

⁷⁶ A focus group discussion conducted on 18 Dec. 2015.

⁷⁷ See <http://bme.vec.go.th/Portals/30/e-book/%E0%B8%9C%E0%B8%A5%E0%B9%82%E0%B8%9E%E0%B8%A5%E0%B8%84%E0%B8%A3%E0%B8%B1%E0%B9%89%E0%B8%87%209.pdf>.

⁷⁸ Levitov et al., 2014.

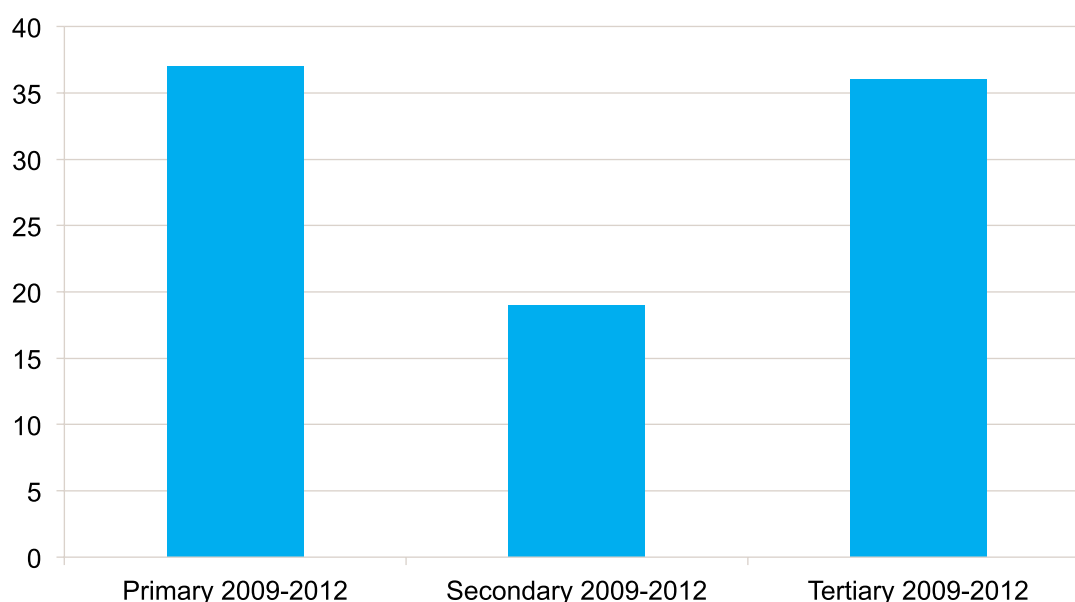
⁷⁹ World Bank, 2013; World Bank, 2014.

The skills mismatch in the youth labour market has become a persistent and growing trend. Overeducation and over-skilling co-exist, with undereducation and under-skilling and, increasingly, with skills obsolescence brought about by long-term unemployment. Such a mismatch makes solutions to youth employment more difficult to find and more time consuming to implement. Moreover, to the extent that young people in employment are overqualified for the job they are doing, society is losing their valuable skills and forfeiting stronger productivity growth that would have been achieved had these young people been employed at their appropriate level of qualification.

Increasing numbers of young people are now turning to available part-time jobs or find themselves stuck in temporary employment. Secure jobs, which were once the norm for previous generations, are becoming less easily accessible for today's young people.

The mismatch between the output of the educational system and the demands of the labour market may be attributable in part to poor planning, but it is also a function of the country's rate of change. Reforms to an educational system take a generation to affect the profile of labour supply. Thailand is a highly open economy, susceptible to shifting forces from the world economy. It accelerated the production of mainstream secondary graduates and tertiary degree holders when early industrialization increased demand for ordinary workers and general managers. At that time, it would have been hard to anticipate the shift to skill-based industries and services; as an open, middle-income economy, Thailand needs the ability to adjust its labour profile in response to shifting demand. That requires much more extensive facilities and support for retraining – in technical skills, workplace skills and language. The community college scheme addresses that need but remains limited.

Figure 8. Unemployment, by educational attainment, 2009–2012 (% of total unemployment)



Source: World Bank indicators, 2015, see <http://wdi.worldbank.org/table/2.5#<last updated 10 Sept. 2015>>.

Students are concerned whether the current education system equips them with the skills needed in a widening labour market under the Association of Southeast Asian Nations (ASEAN) Economic Community. And, while the output of the education system has expanded, there are growing complaints from employers that the schools and universities are not producing people with the skills they need.⁸⁰

⁸⁰ UNDP, 2014.

Planning in times of change

To address the skills mismatch, the Ministry of Education's action plan prioritizes six areas to be developed by 2022:

1. English-language capabilities.
2. Support student transfers within the ASEAN University Network scheme and student exchanges with other member countries.
3. Study regulations and conditions for Thai investment in educational institutions, and amended laws that enable inward investment and movement of teachers and educational officers.
4. Increased level of vocational education to meet regional standards.
5. ASEAN qualifications defined for 224 positions in 33 industries.
6. Studies of labour markets in ASEAN to guide the production of students and encourage them to pursue vocational and technical streams so that they can find employment easily and be accepted in other ASEAN countries.

Two additional special projects are planned for 2013–2018. The first is to prepare Thailand for the ASEAN Economic Community with a budget of 34 billion baht for improving skills training, language teaching, occupational capacity, curricula and research. The second project plans to develop selected regional cities as centres for international education with a budget of 11 billion baht for upgrading curricula, developing human resources and networking.

Public-private partnerships are starting to emerge that conduct their own analyses of the skills gap. For example, the Education and Skills Committee within the Joint Foreign Chambers of Commerce in Thailand (representing around 9,000 foreign companies) was established in June 2014.⁸¹ In 2015 they commissioned a survey among their members to outline the skills and education needed to match labour market demands. These types of initiatives need to be documented and publicized within the wider business community and among the general public.

Bottlenecks and barriers

The following summarizes the main bottlenecks that prevent adolescents from receiving a quality education.

Low quality of education due to inefficient institutional management: There are inefficiencies within education financing; although 25% of the national budget is allocated to the education sector, academic achievement has remained the same for the past decade. There are widespread concerns for the education system's ability to equip youth with the skills needed in a widening labour market under the ASEAN Economic Community.

Schools are under great pressure to achieve key performance indicators and, consequently, vulnerable students are dropped rather than given the support they might need.

Financial access to education: Good education in Thailand has become 'big business'. Education is universal, but it is not free. To place children in 'good quality' schools, parents are saddled with the additional costs of uniforms, stationery and special activity fees. These pose barriers for students from the poorest households, migrant families or unaccompanied adolescent migrants.

Unequal quality of education due to lack of trained resources: There are huge disparities in education quality between rural and urban areas. Rural schools are understaffed and lack trained teachers. Rural teachers with good qualifications are targeted for recruitment to wealthier urban private schools.

Lack of equity focus: Large numbers of students are excluded or at the risk of being excluded from the school system. These include students with disabilities, rural students, students affected by HIV, migrants and stateless children. There are no special facilities for students with disabilities. Specialized programmes are often initiated by other government or non-government agencies and may not be fully sanctioned by the Ministry of Education and thus never become institutionalized.

⁸¹ See www.jfctt.org/jfctt-committees/education-skills-committee-2/about-education-skills-committee/.

Chapter 4. Sexual and reproductive health

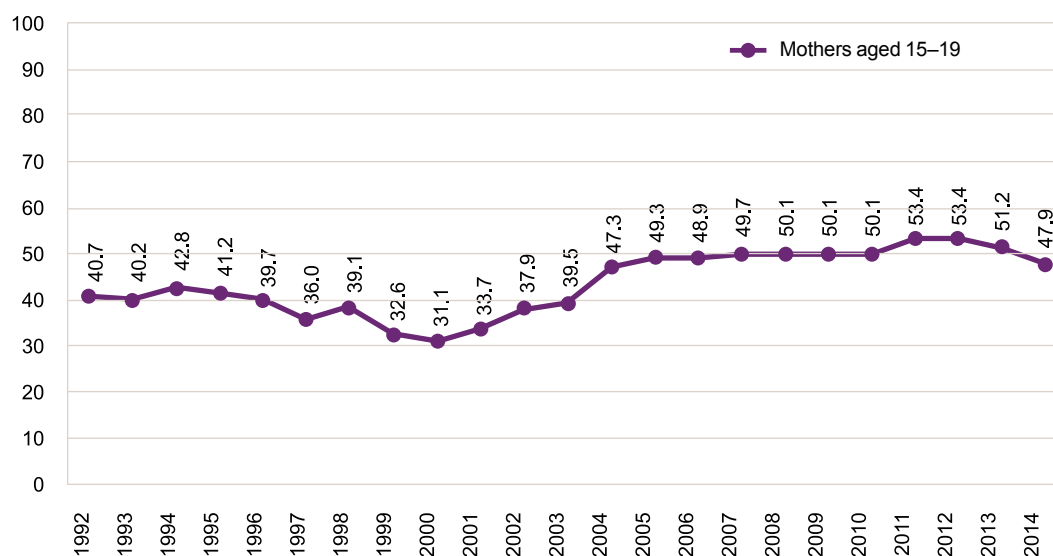
Social inequality between the sexes serves as one of the most important bases for power differentials between women and men, with the effects of gender power on sexuality reflected in men's control of women's sexuality. Cultural norms, which expect women to be inexperienced and naïve in sexual matters and for them to see themselves as passive receptacles of men's sexual passions, are widely held in Thai society.⁸² These damaging gender norms provide the basis of gender inequality in sexual relations. A study from northern Thailand found that young girls experienced a conflict between their desire to adopt new status symbols of modernity and to maintain ideal gender roles as portrayed by Thai social values.⁸³ The most common thing they had heard about becoming a woman was that they would be capable of becoming pregnant when they started menstruating. There was little discussion initiated by teachers about behavioural and emotional changes; young women were only told not to have boyfriends and to concentrate on their studies instead.⁸⁴ Many of Thailand's young people do not live with immediate family members and are thus removed from the traditional social controls related to sexual behaviour. Sexual relationships outside of marriage have become common.



Adolescent pregnancy

Despite the overall birth rates decreasing, the adolescent birth rates rose between 2004 and 2011 before stabilizing or decreasing between 2011 and 2014 (see Figure 9). The lower adolescent birth rate in 2014 is in line with increased condom use among school-going adolescents.⁸⁵ Regional analysis for the same range of years found that the adolescent birth rates were the lowest in the Bangkok region and highest in the north-eastern region (ranging from 13.2% to 19.2% of total births).⁸⁶

Figure 9. Birth rate of mothers aged 15–19 years, 1992–2014



Source: Bureau of Reproductive Health, 2016.

⁸² Archavanitkul, 2011.

⁸³ Fongkaew, 2005.

⁸⁴ *ibid.*

⁸⁵ Bureau of Reproductive Health, 2015.

⁸⁶ UNICEF, 2015.

Between 2000 and 2012, the adolescent birth rate doubled in 19 provinces.⁸⁷ The provinces of Prachuap Khiri Khan, Rayong, Phetchaburi, Kanchanaburi, Saraburi, Samut Prakan and Phichit recorded the largest number of births to girls younger than 15 years. These numbers are a cause for concern because the age of consent for sexual intercourse is 17 years.⁸⁸

Repeat birth rates have risen by 20% since 2004. In 2014, 12.8% of adolescent mothers aged 15–19 had a repeat birth, compared with 10.6% in 2004. Surprisingly, repeat births to adolescent mothers have been lowest in the north-eastern region, the region with the highest adolescent birth rates.⁸⁹

Births to underage mothers come at a risk to the mother and the baby, with a large proportion of underweight infants of adolescent mothers. The rate of underweight infants is 9.9% among mothers of all ages, but it is as high as 19.1% among mothers younger than 15 years and 13% among mothers aged 15–19 years.⁹⁰

Pregnant adolescents and adolescent mothers face numerous barriers to continuing their education, many of which are interrelated. These barriers include being forced out of school, not receiving the support necessary to continue attending school and not wanting to experience stigma from peers, teachers and parents of other students. Social stigma against unplanned pregnancies creates an unsupportive environment for adolescent girls at home, in school and in the community. Adolescent girls, in particular (seldom boys), experience stigmatization from the people closest to them. The greatest health concern for pregnant adolescents result from the increased risk of life-threatening complications associated with an unsafe abortion.⁹¹

The Ministry of Social Development and Human Security launched its strategic plan for the prevention of adolescent pregnancy in 2013. The Ministry's provincial offices coordinate and monitor progress of adolescent pregnancy prevention programmes, tracking direct information flow to adolescents and provincial behaviour change communication campaigns. They also help community-based organizations set up adolescent pregnancy prevention action plans and operations.

Abortion

Abortion in Thailand is illegal except to save the life of the mother or if the pregnancy is due to rape or incest. Only a fully qualified medical practitioner is allowed to carry out the termination, and a legally approved abortion is not available in all hospitals. The procedure for obtaining a legal abortion is cumbersome and must be presented to the medical practitioner before the procedure.

According to a report on post-abortion complications in Thailand, an estimated 200,000–300,000 women of reproductive age seek abortions each year.⁹² In 2011 alone, 10,564 adolescent girls aged 15–19 years were admitted to government medical facilities for complications arising from an abortion or miscarriage. According to the Department of Health's Pregnancy Termination Surveillance Report, 40% of women who sought to terminate a pregnancy were school or university students; 29% were younger than 20 years, and 60.5% were younger than 25.⁹³ Moreover, 67.5% of young women seeking a termination did not intend to get pregnant, and 71.6% did not use any form of contraception (see Table 1). There have been media reports of adolescent mothers having abandoned or harmed their newborn babies.

Table 1. Women who sought an abortion, by age, 2013 (percentages)

Age (years)	Unintended pregnancy	Unprotected sex
15 and younger	0	100
15–19	58.5	79.8
20–24	68.5	73.1
24 and older	74.5	64.2

Source: Bureau of Reproductive Health, Department of Health, 2013.

⁸⁷ UNFPA, 2014.

⁸⁸ *ibid.*

⁸⁹ UNICEF, 2015.

⁹⁰ UNFPA, 2014.

⁹¹ UNICEF Thailand, 2015.

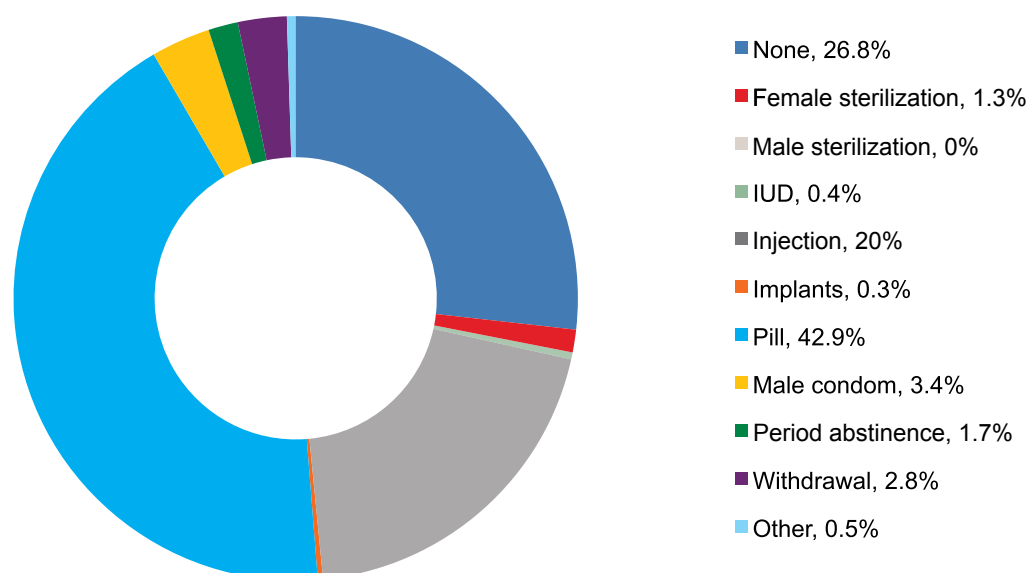
⁹² UNFPA, 2014.

⁹³ PowerPoint presentation on the situation of population and reproductive health by Dr Kittipong Sae Jeng, Reproductive Health Bureau, Department of Health, 18 Aug. 2015.

Contraceptive use

The 2009 Reproductive Health Survey conducted by the National Statistical Office indicated that only 15.7% of sexually active adolescents used contraception. The use of contraception was greatest among married adolescents, at 79.8%. The preferred methods of contraception for married adolescent girls were birth control pills (at 60%) and injections, whereas married boys preferred condoms, followed by birth control pills. Only 8.5% of non-married adolescent girls used birth control pills. Single adolescent boys preferred condoms (see *Figure 10*).

Figure 10. Use of contraception among 15- to 19-year-olds, married or in a union, 2012



Source: NSO, et al., 2012.

In a sample of married adolescent girls, the reasons for not using contraception included: wanting to get pregnant (44%); concerns about health risks (26%); husband rarely home (6%); just having given birth or miscarried (6%); husband forbids it (3%) and other reasons (15%).

In a sample of married adolescent mothers, the reasons for not using contraception included: forgetting to take the pill or to have an injection (38.7%); experimentation with traditional methods (28.9%); did not plan on having sex (25.6%); did not know about contraception (3%); incorrect contraceptive use (0.9%); did not think a pregnancy was possible or thought getting pregnant would be difficult (0.9%); forced to have sex (0.9%); had just given birth or miscarried (0.5%); did not have time to buy contraception or access birth control services (0.6%).⁹⁴

Condom use

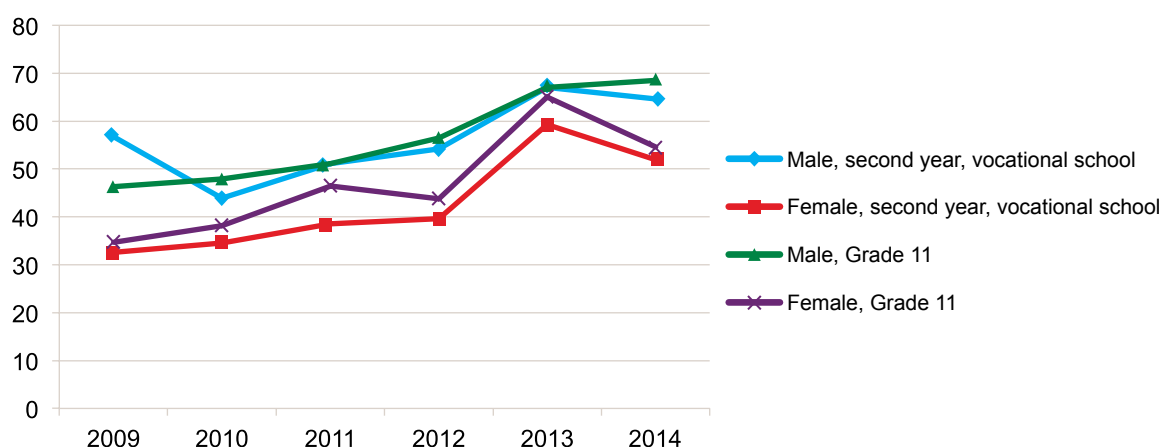
The 2014 Behavioural Surveillance Survey found that 24.2% of males and 18.9% of females in Grade 11 and 46.6% of males and 47.1% of females in second-year vocational school reported sexual initiation before they were 15 years old.⁹⁵ The survey also found that 68.5% of sexually active male and 54.6% of sexually active female high school students used a condom when having sex. The corresponding proportion of sexually active male and female vocational school students was 64.7% and 52%. A much smaller proportion of sexually active female high school and vocational school students, at 25.5% and 19.3%, respectively, used condoms consistently in the three months prior to the survey. This was confirmed by young people aged 15–24 years participating in the ACHIEVED project, in which consistent condom use was reported by only 32% of students, 41.7% of young community workers and 25% of young factory workers.

There was an upward trend in condom use among Grade 11 secondary students and second-year vocational students from 2009 to 2013. There was a 10–15% increase among male secondary and vocational school students and a 20% increase among female secondary and vocational school students. In the 2013–2014 school year, there was a slight decrease in condom use among male and female vocational school students and female secondary school students (see *Figure 11*). Anecdotal information suggests that this decrease in condom use may be due to a decrease in condom production by the main condom manufacturers in 2012.

⁹⁴ NSO, 2009.

⁹⁵ BSS Thailand, 2014.

Figure 11. Percentage of students who used a condom when having sex with a boyfriend or girlfriend, by sex and school grade, 2009–2014

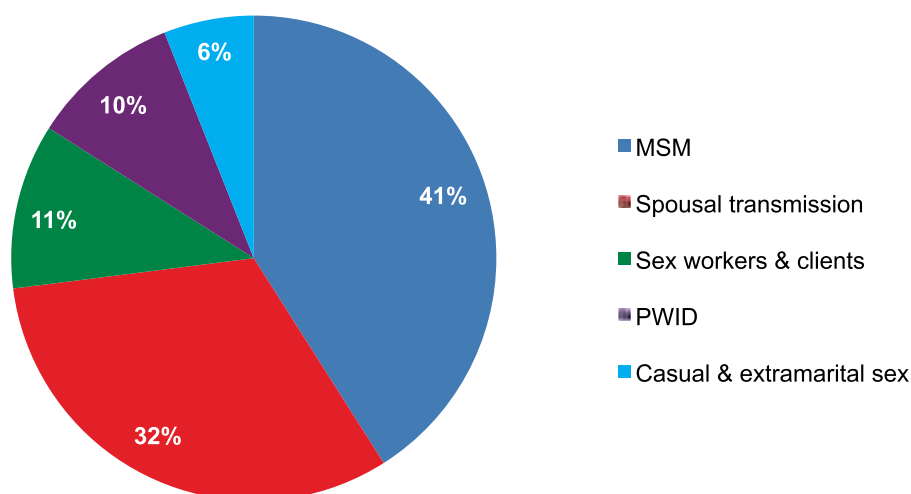


Source: Bureau of Epidemiology, Department of Disease Control, 2014.

HIV and other sexually transmitted infections

According to a 2015 media report, 70% of all sexually transmitted HIV infections in Thailand are occurring among young people aged 15–24 years. Despite a gradual drop in overall HIV prevalence over the past two decades, new infections are rising among young people engaging in high-risk behaviours, such as commercial sex work, injecting drugs and unprotected sex between men (see Figure 12).⁹⁶

Figure 12. Modes of HIV transmission



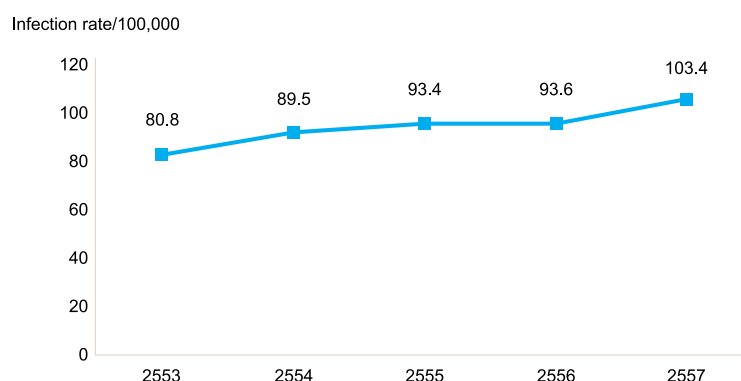
Source: Thailand's National AIDS Strategy, 2014–2016.

From 2010 to 2014, sexually transmitted infections (STIs) increased from 80.8 to 103.4 cases per 100,000 population aged 15–24 years (see Figure 13).⁹⁷ An STI infection significantly increases a person's risk for HIV infection. According to UNAIDS data, STI infections are highest in the northern provinces, the eastern seaboard and Petchaburi Province on the western seaboard.

⁹⁶ Herman, 2014.

⁹⁷ See <http://aidszeroportal.org/> accessed on 30/10/2015.

Figure 13. Sexually transmitted infection rates among young people aged 15–24 years, 2010–2014



Source: Bureau of epidemiology department of disease control 2010–2014.

**STI report covers gonorrhea, Non gonococcal urethritis, Chancroid, Lymphogranuloma venereum (as of 7 September 2015).

Taken from the slide presentation of Deputy Director, Bureau of Reproductive Health

Thailand does not include youth in its sentinel surveillance for HIV. The prevalence of pregnant women (aged 15–24 years) and military recruits (aged 21 years) making antenatal clinic visits are used as a proxy to track trends among young people. The HIV prevalence among both sentinel groups was 0.4% in 2012.⁹⁸ The estimated prevalence among young men and women in the general population was 0.3% and 0.2%, respectively.⁹⁹ Many adolescents in Thailand do not know their HIV status. UNAIDS estimated the number of adolescents living with HIV in 2013 to be 11,000, of which 50% were male.¹⁰⁰

HIV testing and counselling services

In a 2013 study, some 78% of young women aged 15–24 knew where to test for HIV but only 29% had been tested.¹⁰¹ Since then the clinical guidelines for HIV testing and counselling in young people have been successfully changed so that persons younger than 18 no longer need parental consent for HIV testing, there has been little uptake of testing and counselling services by younger adolescents. Many adolescents may be interested in testing, but some remain concerned that their results will be reported to their parents. Others are concerned about the judgemental attitudes of service providers towards underage sex. Adolescents do not want to visit facilities in which staff will lecture them on socially accepted behaviours. Service providers, on the other hand, are concerned about following guidelines that are not supported by law. If parental consent is not obtained, they fear they run the risk that the parents might litigate. Yet other service providers may be unaware of the change in guidelines.

The National AIDS Programme produced operational guidelines on the disclosure of test results – to both services providers and parents or guardians – and the referral for antiretroviral therapy.¹⁰² Since 2011, testing and counselling drop-in centres have been established in key locations around Bangkok, Chiang Mai, Hat Yai and Pattaya.¹⁰³ Civil society has been the mainstay for delivering community-based HIV testing and counselling services by providing case management, with funding support from the Global Fund and the United States Agency for International Development.

Sexuality education

Sexuality education (or sex education) began in Thailand in 1978.¹⁰⁴ Sexuality education content was integrated into the basic education curriculum by the Office of the Vocational Education Commission in 2004¹⁰⁵ and the Office of the Basic Education Commission in 2008.¹⁰⁶ Quality, content and coverage were expanded nationwide by the Teenpath Project of PATH Thailand,¹⁰⁷ with funds from the Global Fund and the Thai Health Promotion Foundation. A 2013 review found that a total of 1,754 basic education schools (5.6%) and 319 vocational schools (37.4%) taught sex education (see Figure 14).¹⁰⁸

Most Thai parents do not teach their children about sex education. The limitation of sex education in the family is a restriction imposed by traditional Thai culture, in which sex education is not considered a parental duty and parents are prevented from discussing the topic. There is also the belief that talking about sex will encourage young people to experiment with sex.¹⁰⁹

⁹⁸ See <http://aidszeroportal.org> <accessed 30 Oct. 2015>.

⁹⁹ UNAIDS, 2015a.

¹⁰⁰ UNAIDS, 2013.

¹⁰¹ UNAIDS, 2013.

¹⁰² National AIDS Committee, 2015.

¹⁰³ UNAIDS, 2015b.

¹⁰⁴ Thaweesit and Boonmongkon, 2012.

¹⁰⁵ UNESCO, 2014.

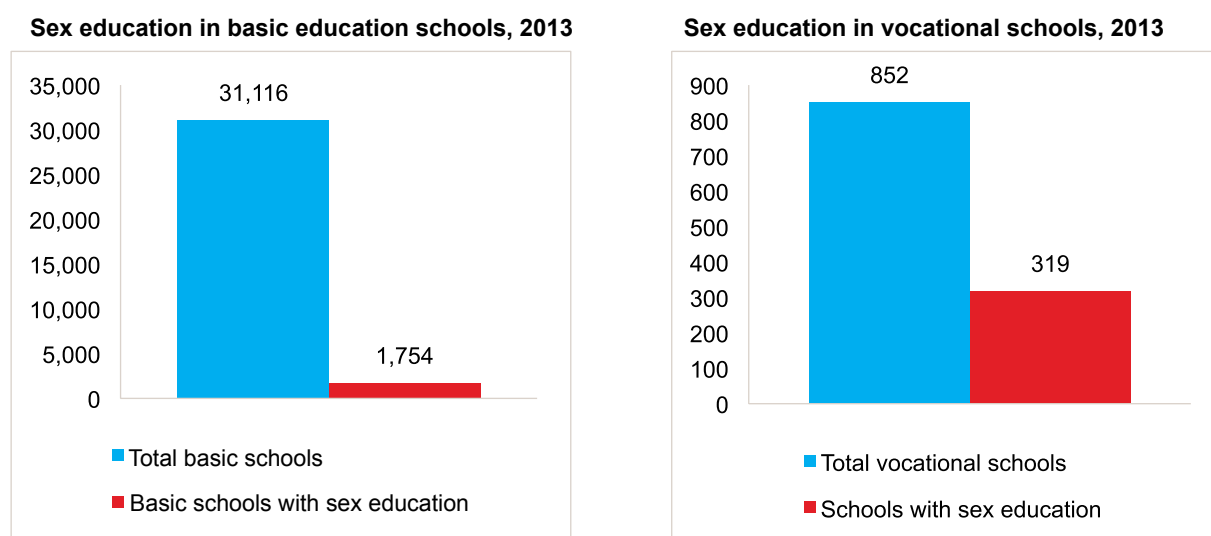
¹⁰⁶ MOE, 2008.

¹⁰⁷ Thaweesit and Boonmongkon, 2012.

¹⁰⁸ See <https://aidszeroportal.org> <accessed 30 Oct. 2015>.

¹⁰⁹ Sridawuang, Pfeil and Crozier, 2010.

Figure 14. Availability of sex education in basic education and public vocational schools



Source: UNICEF and Mahidol University, 2013.

Among the various health and social concerns, adolescent pregnancy is currently the most prominent in Thai society. Recognition of this issue led to the enactment of the Teenage Pregnancy Prevention and Alleviation Act in 2016, which mandates the provision of sexuality education in educational institutions.¹¹⁰ In 2015, UNICEF supported a team at Mahidol University to review the implementation of sexuality education in 373 secondary schools and 25 vocational colleges. Learners, teachers, guardians and school administrators were interviewed using quantitative and qualitative methods.

The review found that sexuality education is provided in nearly all the schools looked at, with 99% of general secondary teachers and 93% of vocational teachers reporting that sexuality education was provided in their school. Between 84% and 90% of the surveyed general secondary students and 75% of the vocational students said that sexuality education had been provided in the current school year. They also reported that sexuality education is provided both as a separate subject and as integrated content. Half or more than half of teachers providing sexuality education had received no specific training. Evaluation is mostly based on tests of students' knowledge on sexuality.¹¹¹



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All six content areas asked about in the survey (gender; sexual development, health and behaviour; sexual rights and citizenship; violence, identity and relationships; other topics) are taught. On average, students reported 63–90% of topics covered in each area. The topic area with the lowest coverage was sexual rights and citizenship. The prevention of unwanted pregnancy and sexual anatomy and development are most consistently covered.

“The key message that we get from sex education in schools is that sex is bad. Lessons focus on the biology of pregnancy and childbirth. Details about relationships, intimacy or the mechanics of sexual intercourse are never discussed. Information about same-sex attraction and same-sex behaviour is completely avoided.”
 – Adolescent key informant

The percentage of surveyed youth who could answer five HIV knowledge items correctly was around 20%, a finding that has remained unchanged since 2012. Young women and young people from the southern provinces have the lowest levels of HIV knowledge. Poor young women and migrant or stateless young women are among the most disadvantaged. Young women in the poorest households have considerably less knowledge (at 40.6%) than young women in the richest households (at 61.4%), as do young women in non-Thai households (at 29.2%), compared with Thai-headed households (at 52.7%).¹¹²

Students assessed themselves to have good knowledge about contraception and menstruation, but only a minority could answer multiple-choice questions about menstruation correctly. Self-reported regular use of emergency contraceptives suggests that adolescent girls still lack critical negotiation skills.¹¹³

¹¹⁰ Mahidol University, 2016.

¹¹¹ *ibid.*

¹¹² NSO, et al., 2012.

¹¹³ Mahidol University, 2016.

Problematic attitudes about sexuality and gender are still common among students. Many students have attitudes that compromise gender equality, affirm the use of domestic violence in some situations or reject the sexual rights of various groups. For example, 25–57% of students agreed with the statement: “In a family, men should have more say than women over important decisions”, while 13–50% of students thought that “sexual relations with someone of the same sex is wrong”. The teacher survey indicated that most teachers held attitudes that were supportive of gender equality and rejected domestic violence. However, most teachers thought that sex between unmarried young people was unacceptable, and some thought that sexual relations with someone of the same sex was also wrong.¹¹⁴

Most parents think that sexuality education should be taught, but some parents wonder whether it encourages students to have sex. School directors accept the importance of sexuality education but give it limited support. Some directors stated that although sexuality education is important, they must set teaching priorities. In some cases, they positioned sexuality education as a lower priority than other curriculum areas. Some directors said that they chose to use scarce resources on issues they consider to be ‘more important’.¹¹⁵

Innovative initiatives are emerging in the private sector on increasing awareness of sexual and reproductive health.¹¹⁶

Sexual and reproductive health services

“My mother is the one who decides when and if I need to see a doctor. If it is decided that I need to go see one, she will always insist on going with me.” – Adolescent key informant

The first National Policy and Strategic Plan on Reproductive Health (2010–2014) was approved in September 2010. The goal of the plan was to increase the quality and availability of sexual and reproductive services for most-at-risk adolescents in government hospitals. Efforts have been made to build the capacity of service providers, under the banner of ‘bright and healthy adolescent’. Service providers are trained to be friendlier to adolescent clients, to encourage them to use condoms and birth control methods, to provide health care for the children of adolescent mothers and to follow up on pregnant adolescents and the delivery of their babies at provincial and national levels. The Ministry of Public Health is supporting integrated reproductive health strategies designed to bring together all agencies and organization in each province, including the Government, the private sector and civil society organizations. The Stepping Towards Municipal Reproductive Health policy focuses on the holistic prevention of adolescent pregnancy via links with communities, families, schools and public health facilities.

Bottlenecks and barriers

The following summarizes the main bottlenecks that prevent adolescents from enjoying a healthy sexual life and quality reproductive health care.

Strong social norms on teenage sexuality: Adolescents’ perceptions of normal, healthy sexual relationships with a boyfriend or girlfriend contradict Thai society values of abstinence until marriage. Gender norms and social stigma perpetuate adolescents’ ignorance about reproductive health and shared responsibilities in a relationship. Young females are discouraged from seeking information and services about reproductive health while being expected to shoulder the responsibility of pregnancy prevention and the consequences should they get pregnant. Young males are encouraged through media and peer pressure to increase their sexual prowess. Social stigma against unplanned pregnancies and adolescent sexuality is a barrier to adolescents learning about and/or accessing contraception and other reproductive health services.

Unequal availability and quality of services: While youth-friendly health services were expanded to all provinces in 2012, not all government hospitals provide these services; and where services do exist, there is no mechanism for quality assurance. Adolescents do not have easy access to semi-permanent birth control because it is expensive and not covered by the universal health care system.

Low use of available services: Even where services are available, use remains low. This is due mainly to social stigma against adolescent sexuality, which prevents adolescents from learning about and/or accessing contraception and other reproductive health services. Negative attitudes and behaviours of teachers, parents and service providers are barriers to adolescents’ access to health and social services because they discourage open communication and requests for help. Negative attitudes are heightened for LGBTI adolescents. Young men who have sex with men, young sex workers and young injecting drug users face multiple barriers in accessing information and counselling, prevention and treatment services.

Confusing legal framework and policies: There is a mismatch between the age at which adolescents can consent to sex, the age at which they can access sexual and reproductive health services, the age at which they can marry, the age at which they can test for HIV and the age at which they can receive HIV treatment without parental consent. The age at which many adolescents begin having sex and their need for sexual and reproductive health service also differs. There are still discrepancies between formal and religious or customary law on the minimum age of marriage in some communities.

¹¹⁴ *ibid.*

¹¹⁵ *ibid.*

¹¹⁶ See www.bangkokpost.com/print/434020/.

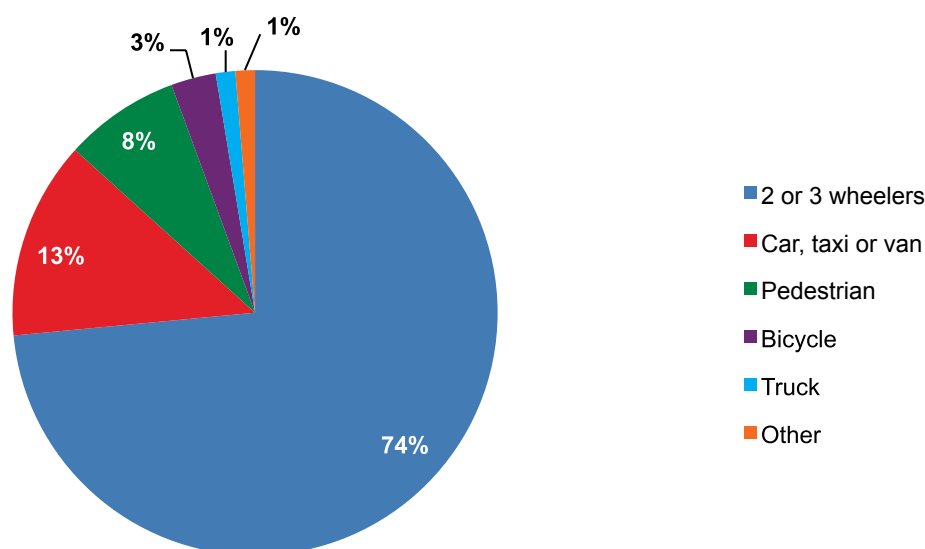
Chapter 5. Non-communicable diseases and mental health

Fatal and non-fatal injuries

The mortality rate from fatal injuries in adolescent boys (at slightly more than 1%) is more than double the mortality rate in adolescent girls (at 0.4%).¹¹⁷ The major causes of death are motor vehicle injuries and drowning.¹¹⁸ Fatal road traffic injuries involving motorcycles account for the majority of deaths of adolescent boys (see Figure 15). More than 36,000 adolescents are seriously injured or permanently disabled from road traffic injuries each year.¹¹⁹ Of all road traffic deaths recorded in 2013 (14,789 cases), 14.9% (2,207 cases) involved adolescents.¹²⁰ The risk behaviours for fatal injuries are not wearing helmet and drinking alcohol.¹²¹ Death from road traffic injuries represent around 6.6 billion baht of economic loss each year,¹²² or 31.9% and 12.8% of total disability-adjusted life years among young men and women aged 15–29, respectively.¹²³ Drunk driving is an issue of huge concern. The Road Safety Directing Centre was established by the Thai cabinet in 2003 as the national centre for road traffic injury prevention.¹²⁴ Road safety is part of the national policy agenda, but its implementation is hardly enforced.



Figure 15. Distribution of road traffic deaths, by type of user, 2009–2010 (percentages)



Source: WHO, 2013.

In Thailand, non-communicable diseases account for an estimated 71% of all deaths. The risk factors for non-communicable diseases in the Thai population are smoking, alcohol consumption, raised blood pressure and obesity, but with a varying gendered impact. More prevalent among men are smoking (46% of men, 5% of women) and alcohol consumption (13.8% of men, 0.8% of women), whereas raised blood pressure is about equal (24.1% for men, 20.7% for women) and obesity is more common among women (at 12%, while it is 5k% for men).¹²⁵ The behaviours leading to non-communicable diseases in later life have their origin in adolescence and early adulthood.

¹¹⁷ *ibid.*

¹¹⁸ *ibid.*

¹¹⁹ OPP, 2014.

¹²⁰ BNCD, 2014.

¹²¹ BOE, 2012.

¹²² THPF, 2008, see <http://corp.thaihealth.or.th/resource-center/stats/accidents> <accessed 12 Nov. 2015>.

¹²³ IHPP, 2014.

¹²⁴ Road Safety Directing Center, see www.roadsafetythailand.com/main/index.php/aboutus-th/2011-12-24-07-00-01 <accessed 24 Nov. 2015>.

¹²⁵ WHO non-communicable disease country profile, 2014.

Substance use

Alcohol

Adolescents who begin drinking alcohol before they are 15 years old are more likely to become alcohol dependent than those who wait until their 20s to drink regularly. Adolescents also tend to be less sensitive to alcohol's sedative qualities and are thus able to stay awake longer with higher blood alcohol levels than older drinkers.¹²⁶

The prevalence of alcohol consumption¹²⁷ among Thai youth increased by 15.1% in the past eight years (see Table 2). This corresponded to around 2.5 million people, with 38.7% of them frequent drinkers and around 10% new drinkers.¹²⁸ The average age when first drinking decreased from 17.2 years in 2007 to 16.7 years in 2014.¹²⁹ There has also been a marked increase in the proportion of female drinkers (aged 15 or older), from 9.1% in 2007 to 12.9% in 2014.¹³⁰ Thai adolescents spend a monthly average of 367 baht on alcohol. The majority of surveyed adolescents said they bought alcohol from grocery shops (75%) and drank alcohol at home (42%).¹³¹ The annual economic loss due to alcohol is as high as 1,510 billion baht (1.97% of GDP).¹³² Alcohol is the top health risk for adolescents in Thailand because it accounts for more than 70% of road accidents.¹³³

Table 2. Self-reported alcohol use, 2015 (percentages)

	Students aged 13–15 years		Students aged 16–17 years	
	Boys	Girls	Boys	Girls
Percentage of students who currently drink alcohol	20.7	17.4	45.4	22.4
Percentage of students who drink so much alcohol that they were heavily drunk one or more times in their life	19.2	18.2	47.3	32.4
Percentage of students who drank alcohol before age 14 years for the first time (among current drinkers)	73.5	65.9	39.1	24.5

Source: Global School-based Student Health Survey 2015.

The minimum age for purchasing alcohol in Thailand is 20 years. However, more than 80% of grocery shops and convenience stores sell alcohol to uniformed students and those younger than 20 years. Promotional campaigns to reduce alcohol consumption in various population groups have had limited effects.¹³⁴

Tobacco

Smoking accounts for more than 50,000 deaths in Thailand each year. While the prevalence of smoking among the general population levelled off at around 20–23% in the past decade, the proportion of young people (aged 15–24) who smoke substantially increased from 9.8% in 2001 to 14.7% in 2014 (see Table 3).¹³⁵ From 2007 to 2014, the average age at first smoking among young people (aged 15–24) decreased from 16.8 to 15.6 years. In addition, the average number of cigarettes smoked per day increased from 8.5 cigarettes to 10.1 cigarettes.¹³⁶ From 2009 to 2011, the proportion of adolescent smokers (younger than 18 years) who wanted to quit smoking declined from 60.6% to 42.6% of smokers and from 6.2% to 2.2% for those who successfully quit smoking.¹³⁷

Table 3. Self-reported tobacco use, Global School-based Student Health Survey 2015

	Students aged 13–15 years		Students aged 16–17 years	
	Boys	Girls	Boys	Girls
Percentage of students who currently use any tobacco product	19.7	7.6	26.7	7.0
Percentage of students who currently smoke cigarettes	14.7	4.6	21.9	5.3
Percentage of students who reported that persons smoked in their presence on one or more days in the past 7 days	40.3	37.9	54.1	48.0

Source: Global School-based Student Health Survey 2015.

¹²⁶ McNeely and Blanchard, 2009.

¹²⁷ Definition: The survey participants who reported drinking alcohol in the past 12 months.

¹²⁸ Thai Health Promotion Foundation, 2014, see <http://goo.gl/0MqJBR> <accessed 6 Nov. 2015>.

¹²⁹ *ibid.*

¹³⁰ NSO, 2015.

¹³¹ Center for Alcohol Studies, 2013.

¹³² Thairath Online, 2011, see www.thairath.co.th/content/198664 <accessed 6 Nov. 2015>.

¹³³ MOPH, 2015.

¹³⁴ Stop Drink Network, 2015, see www.stopdrink.com/ <accessed 6 Nov. 2015>.

¹³⁵ National Statistical Office, 2015.

¹³⁶ *ibid.*

¹³⁷ Bureau of Tobacco Control, 2013.

Adolescents spend an average 409 baht per month on cigarettes.¹³⁸ The total economic loss due smoking is estimated at around 9.8 billion baht, equivalent to 0.5% of the 2006 GDP of Thailand.¹³⁹ Grocery shops are the most common place for adolescents to buy cigarettes, particularly loose cigarettes that are illegal to buy or sell.¹⁴⁰ Adolescent smokers often smoke on school premises which suggests lax enforcement of school health policies.

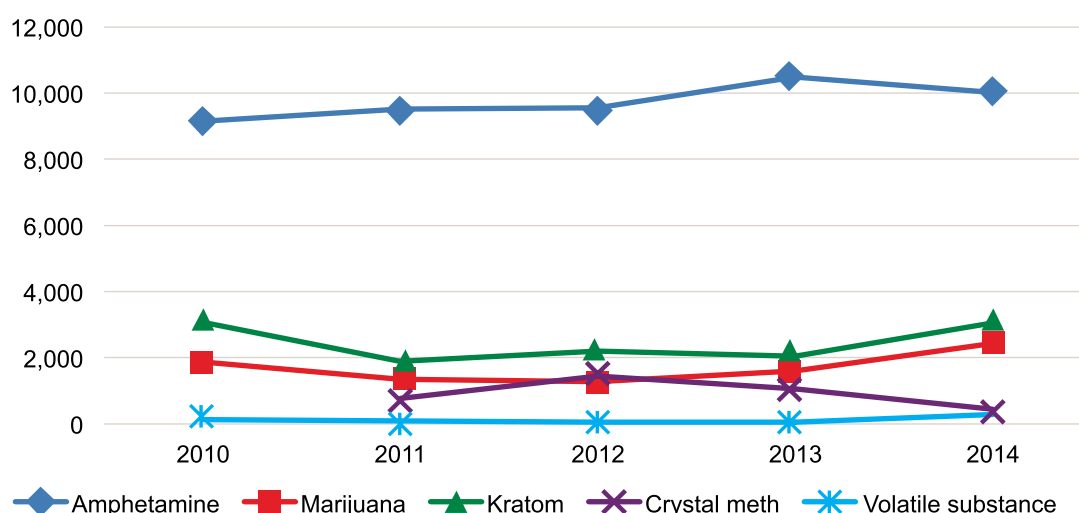
Reducing smoking among adolescents has become the focus of health policies in Thailand. The prevalence of smoking in adolescent aged 15–19 was a key performance indicator for the Ministry of Public Health (MOPH) in 2014–2015.¹⁴¹ The new Tobacco Products Control Act aims to prevent new smokers and reduce smoking among adolescents and is in the process of getting approval from the cabinet. Upon approval, the minimum age to buy cigarettes in Thailand will be raised from 18 to 20 years, and promotional activities and sponsorship of tobacco products will be restricted.¹⁴²

Illicit drugs

“The one good thing about Thaksin’s war on drugs is that it made drugs difficult to get and expensive, so people stopped using them. Now, it is difficult to leave home without someone approaching you about drugs.” – Adolescent key informant

An estimated 1.7 million young people (aged 12–24 years) in Thailand use drugs. Cannabis (marijuana) herb remains the most widely used drug, followed by kratom. Marijuana, methamphetamine (*ya ba*) and crystalline methamphetamine (*ya ice*) are the top three drugs used by Thai adolescents.¹⁴³ The average adolescent recreational drug user is aged 15–17 years.¹⁴⁴ A report by the Department of Justice shows that in the period from 2010–2014 *ya ba* accounted for 60–70% of all juvenile drug offences (see Figure 16).

Figure 16. The number of juvenile drug cases handled by all Juvenile Observation and Protection Centres, by the top-five drug categories, 2010–2014



Source: Department of Juvenile Observation and Protection.

Around 25% of the population who seek drug treatment services are younger than 20 years.¹⁴⁵ In 2013, there were more than 200,000 patients aged 12–24.¹⁴⁶ According to the Princess Mother National Institute on Drug Abuse Treatment at there are 180 outpatient treatment services in 122 public hospitals, 36 private hospitals and 40 rehabilitation centres.¹⁴⁷

138 National Statistical Office, 2015.

139 Voice TV News, 2013, see <http://news.voicetv.co.th/thailand/74136.html> <accessed 10 November 2015>.

140 Bureau of Tobacco Control, 2013.

141 MOPH, 2014.

142 THPF, 2015, see <http://en.thaihealth.or.th/NEWS/49/New%20Tobacco%20Control%20Act%20Approved%20by%20the%20Cabinet> <accessed 12 Nov. 2015>.

143 UNODC, 2013.

144 ABAC Poll Research Center, 2011.

145 OPP, 2014.

146 *ibid.*

147 See www.thanyarak.go.th/eng/index.php?option=com_content&task=view&id=1638&Itemid=132 (last update 1 July 2015) <accessed 30 Oct. 2016>.

Nutrition

Stunting

Stunting remains one of the primary nutrition problems among adolescents in Thailand.¹⁴⁸ The 2014 Department of Health's annual report pointed out that 16.7% of children and adolescents aged 6–18 were below standard height in 2013,¹⁴⁹ which far exceeds the World Health Organization's 'diamond' rating of 5%.¹⁵⁰ Moreover, stunting among adolescents has increased, from 7.9% in 2003¹⁵¹ to 8.9% in 2013,¹⁵² corresponding to an estimated 800,000 stunted adolescents aged 10–19 years.¹⁵³ The MOPH is aware of the issue and aims to increase the average height of 18-year-olds, from 167 cm to 177 cm in young men and from 157 cm to 165 cm in young women by 2025 by encouraging the consumption of milk, physical exercise and healthy diets.¹⁵⁴

The Fund for School Lunch Program, established in 1992, is an effort by Government to end malnutrition among pre-school and primary school-age children.¹⁵⁵ The budget was recently increased by 25 billion baht. An additional budget for the other two meals of the day will be also provided in the near future to children in remote areas and up to Grade 9 students.¹⁵⁶ However, obstacles remain, including poor, substandard food quality and lack of school nutritionists.¹⁵⁷

Anaemia

Anaemia surveillance programs cover children from birth to primary school and pregnant women. Reliable anaemia data for adolescents are scarce. A cross-sectional study conducted in 2011 among 872 adolescents in Chanthaburi Province found an anaemia prevalence of 6.2%. Prevalence of anaemia was higher among students who didn't live with their parents (at 14.5%), were underweight (at 10.2%), had improper health behaviours (at 10.1%), and were older than 14 years (at 9.3%).¹⁵⁸ Other studies have attributed anaemia to thalassemia or haemoglobinopathy in north-eastern Thai and ethnic hill-tribe children.¹⁵⁹ The MOPH initiated policy guidance on the provision of iron supplements to children and adolescents in 2016.¹⁶⁰

Obesity

According to the Department of Health, around 8.9% of children and adolescents aged 6 to 18 were overweight or obese in 2013,¹⁶¹ a decrease from 13.2% in 2012 (see Figure 17).¹⁶² However, the number of obese adolescents remains high. In 2014, 9.9% of school-age children (aged 5–14 years) were reported to be overweight,¹⁶³ which still exceeds the diamond rating of 7% recommended by the World Health Organization.¹⁶⁴ Obesity is more common among children and adolescents (aged 6–18) living in urban areas.¹⁶⁵ The prevalence is also higher in boys than in girls and among older adolescents than younger ones.¹⁶⁶



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148 Definition: Short is between -1.5 standard deviation and -2 standard deviation of standard height-for-age. Stunted is less than -2 standard deviation of standard height-for-age. Below standard height includes both short and stunted height.

149 DOH, 2015.

150 DOH, see http://eng.anamai.moph.go.th/main.php?filename=02_ <accessed 30 Oct. 2015>.

151 DOH, 2006.

152 DOH, 2015.

153 DOH, 2006.

154 OBEC, see http://pr.moph.go.th/iprg/include/admin_hotnew/show_hotnew.php?idHot_new=73465 <accessed 30 Oct. 2015>.

155 MOPH, 2015, see http://school lunch.obec.go.th/data/about_fund.html <accessed 30 Oct. 2015>.

156 Manager Online, 2015, see www.manager.co.th/QOL/ViewNews.aspx?NewsID=9580000037213 <accessed 30 Oct. 2015>.

157 Komchadluek Online, 2015, see www.komchadluek.net/detail/20150120/199787.html <accessed 30 Oct. 2015>.

158 วิรพงษ์ หนูผล (2556) ความชุก และปัจจัยที่มีความสัมพันธ์กับภาวะโลหิตจางในนักเรียนมัธยมต้น จังหวัดจันทบุรี คณะสาธารณสุขศาสตร์ มหาวิทยาลัยมหิดล [Prevalence and Risk Factors among Adolescents in Junior High School of Chanthaburi Province, Thailand]

159 Panomai, et al. 2010, pp. 1317–1322; and Yanola, Kongpan and Pornprasert, 2014.

160 HITAP, 2557.

161 DOH, 2015.

162 DOH, 2014.

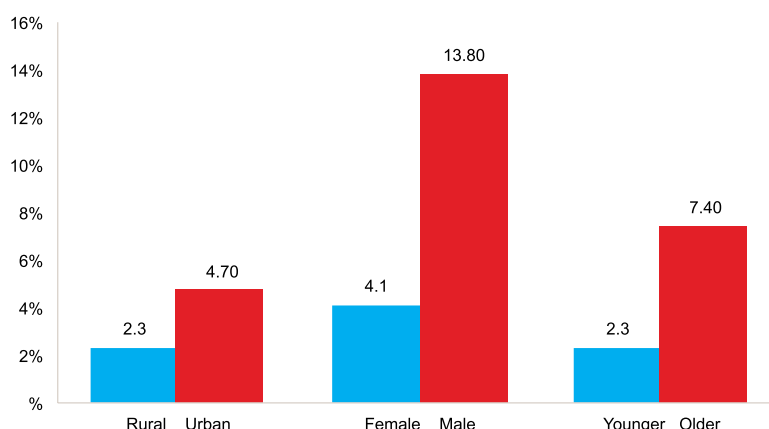
163 DOH, 2015, see <http://goo.gl/FcpVUt> <accessed 30 Oct. 2015>.

164 DOH, see http://eng.anamai.moph.go.th/main.php?filename=02_thps <accessed 30 Oct. 2015>.

165 DOH, 2006.

166 ibid.

Figure 17. Prevalence of obesity, by region, sex and age, 2003 (percentages)



Source: National Survey of Nutrition in Thailand, 2003.

A survey in 2006 suggested that a Thai student spent on average 9,800 baht a year on snacks, which is more than threefold the money spent on education (at 3,024 baht a year).¹⁶⁷ The proportion of Thai children aged 6–14 who eat snacks and drink sodas increased nearly twofold in the period from 2004 to 2007.¹⁶⁸ The 2012 National Dental Health Survey found that 9.6% of 12-year-olds drank sodas every day and 38% of 12- to 15-year-olds ate snacks every day, resulting in 50–60% of adolescents having decayed teeth.¹⁶⁹

The Strategic Framework for Food Management of the Thai National Food Commission aims to reduce obesity in school-aged children by 0.5% per year by 2024.¹⁷⁰ The Thai People Flat Belly programme is a campaign to promote healthy eating habits, physical exercise and emotional health in the Thai population.¹⁷¹ Campaigns, however, are not backed up by legislation, hence there is limited cooperation from schools and communities.¹⁷² A recent policy recommendation discussed raising a sugar tax on sweetened beverages.¹⁷³

Mental health

The prevalence of depressive disorder among Thai adolescents aged 15–24 is estimated to be around 0.3–2.1%. Stress is a primary contributor to suicide risk, and educational attainment is the main cause of stress in adolescents. Around 30–50% of students at all education levels reported academic stress. Data from the Rajanagarindra Institute for Child and Adolescent Mental Health services indicate that many Thai adolescents have sought mental health services. From 2011 to 2013, the number of adolescents seeking care and support from the institute increased by 63%, from 7,359 client visits to 10,014 client visits. The Rajanagarindra Institute provides mental health service for adolescents in Thailand. The Smart Teen Clinic dedicated to providing mental health services to adolescents opened in 2012.

After motor vehicle injuries suicide is the leading cause of death among Thai adolescents.¹⁷⁴ The number of completed suicide cases among adolescents has remained stable in the past several years (from 233 cases in 2006 to 231 cases in 2013).¹⁷⁵ In 2011, the rate was at 3.43 suicides per 100,000 population aged 15–19 years. Adolescent boys are three times more likely to complete a suicide attempt than young women. Risk factors for suicide include depression or other mental disorder, a family history of suicide, family violence and exposure to the suicidal behaviour of others. Depression is the main cause of suicide¹⁷⁶ in adolescents, with one in three adolescents who attempted suicide reporting depressive disorder.¹⁷⁷

The Student Care and Assistance System¹⁷⁸ is a process of providing care and support to students. Teacher-counsellors work as the main implementing personnel in close collaboration with other relevant teachers, administrators, parents and external services. The Department of Mental Health defines the term ‘care and assistance’ as the process of providing support to students for the prevention of problems and intervention to solve students’ problems with implementing methods and tools for teacher-counsellors and other relevant personnel.

¹⁶⁷ Thai Health Promotion Foundation, see <http://goo.gl/pz1P86><accessed 30 Oct. 2015>.

¹⁶⁸ *ibid.*

¹⁶⁹ DOH, 2013.

¹⁷⁰ PNIC, 2015, see www.pnic.go.th/web/adnoob/core/File/1001.docx<accessed 30 Oct. 2015>.

¹⁷¹ DOH, see <http://nutrition.anamai.moph.go.th/web/data.html><accessed 30 Oct. 2015>.

¹⁷² HITAP, 2013.

¹⁷³ Thai Health Promotion Foundation, 2014, see <http://goo.gl/XpAsqy><accessed 30 Oct. 2015>; and Khaosod, 2015, see www.khaosod.co.th/view_newsonline.php?newsid=TVRReU56RXIPRGd3Tmc9PQ<accessed 30 Oct. 2015>.

¹⁷⁴ THPF, 2012, see <http://goo.gl/XChKKF><accessed 6 Nov. 2015>.

¹⁷⁵ DMH, see www.dmh.go.th/report/suicide/age.asp<accessed 6 Nov. 2015>.

¹⁷⁶ DMH, 2005, see www.dmh.go.th/news/view.asp?id=947<accessed 6 Nov. 2015>.

¹⁷⁷ THPF, 2009, see <http://goo.gl/EiY4GC><accessed 6 Nov. 2015>.

¹⁷⁸ Department of Mental Health website, see http://eng.anamai.moph.go.th/main.php?filename=02_thps<accessed 20 Nov. 2015>; and กรมสุขภาพจิต กระทรวงสาธารณสุข (2544) คู่มือครูที่ปรึกษา ระบบการดูแลช่วยเหลือนักเรียน.

Bottlenecks and barriers

The following summarizes the main bottlenecks that prevent adolescents from enjoying good health and health care.

Limited availability of targeted services and programmes that teach health-promoting behaviours and skills to adolescents: National non-communicable disease prevention efforts have successfully targeted external mechanisms, including excise taxes, smoking bans, limits on alcohol sales, banning tobacco and alcohol advertising and putting warning labels on cigarette packages. However, limited funds have been invested in teaching children and adolescents about health-promoting behaviours and giving them the skills to refuse tobacco, alcohol, drugs and fast food. Similarly, information on alcohol and tobacco are either not included in drug and substance use curricula or not taught. Prevention efforts focus on negative messaging – they do not focus on skill development to assess the social and physiological impact of drug use. Substance use prevention competes with other health-related topics (such as HIV and sexual and reproductive health) for time and space in the curriculum.

Weak enforcement of laws: Despite the stepped-up efforts to prohibit underage sales of alcohol and tobacco, there is often weak enforcement from both law enforcement and retailers due to the social sanction of the use of these substances. Adolescents also may be influenced by alcohol and tobacco brand recognition through the sale of other products, such as clothing.

Unequal availability of treatment services: Treatment services for drug and substance abuse may be difficult to access because they are not available in remote areas and appropriate referral is unavailable. The telephone hotlines for mental health services, 1323 and 1667, are difficult to reach and it is unlikely that the young person will be able to talk to the same counsellor each time they call.

Social norms and stigma: Students do not want to acknowledge or reveal the symptoms of depression out of fear of stigmatization.

Lack of trained or skilled human resources: Teachers and teacher-counsellors do not always have the training to recognize symptoms of depression in students and do not have the capacity to provide appropriate counselling to assess the level of depression and/or suicidal ideation and have difficulty making appropriate referrals for specialized services. Only a small number of district hospitals have child and adolescent psychologists on staff. The Ministry of Education lacks the funding to support child and adolescent psychologists in schools. The telephone hotlines for mental health services (1323 and 1667) are difficult to reach, and it is unlikely that a young person can talk to the same counsellor each time they call.



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Chapter 6. Social protection

Violence and abuse

Gender inequality manifests itself in high rates of violence (31,866 women and children reported abuse and sought assistance from the One-Stop Crisis Centres), and in low levels of women's political participation.¹⁷⁹

Violence in schools

Violence in schools is prevalent, and many forms are socially condoned. Corporal punishment, verbal abuse and neglect are deemed as acceptable. A survey on attitudes of teachers towards student discipline in 2005–2008 found that 60% of teachers think that it is appropriate to beat children to cultivate discipline. Bullying in schools is a highly neglected problem by teachers, students and the school administration.

Plan Thailand conducted a survey among 600 students in Grades 7–12 and found that verbal abuse, including quarrels, scolding and mocking, was common. Teachers use severe verbal abuse as well as corporal punishment. A survey conducted by National Public Health Foundation among 3,047 students in Grades 4–9 revealed that 40% of students had been bullied at least two to three times a month.¹⁸⁰ Acts of bullying include verbal abuse and mocking (47.9%), mocking based on skin colour and race (27.8%) and sexual abuse (10.7%). The Ramjitti Institute estimated that approximately 700,000 students are physically and verbally abused by their peers.

In addition, there is increased evidence of bullying towards LGBTI students. According to a study conducted by Mahidol University,¹⁸¹ 55.7% of self-identified LGBTI students reported having been bullied in the month prior to the survey because they were LGBTI. Nearly one third (30.9%) experienced physical abuse, 29.3% reported verbal abuse, 36.2% reported social abuse and 24.4% reported being victim of sexual harassment. Even among students who identified as LGBTI, 24.5% reported having been bullied in some way because they were perceived to be transgender or attracted to the same sex. Few adolescents, about one third, did something in response to bullying, like consulting a friend, fighting back or telling a teacher. Schools generally do not have specific anti-bullying policies, let alone LGBTI-specific anti-bullying policies. The Mahidol study found that a school's response generally consisted of punishing perpetrators when bullying was reported. Given that much of society holds negative attitudes about sexuality, the study also found that teachers need a lot more support to understand sexual and gender diversity issues in order to integrate their understanding into comprehensive sexuality education interventions.

Sexual violence

“Our society still condones sexual violence and rape. The courts and legal procedures are often pursued from the male perspective. People put pressure on to discourage victims from fighting against abuse because they think that sexual abuse against children is not a serious crime. They do not see the problem from the children's perspective.” – Supensri Pungkoksung, head of the Gender Equality Promotion Centre

The One-Stop Crisis Centre was launched in 1999 with the mandate to provide one-stop services to victims of violence through the operation of multidisciplinary team. A Crisis Centre now exists in 96 provincial hospitals and 734 district hospitals. There is evidence to support that sexual violence against adolescent girls is increasing.¹⁸² In 2013, a total of 31,866 children and women (or around 87 persons per day) reported abuse and sought assistance from One-Stop Crisis Centres.¹⁸³ That finding represents an increase of 19,067 cases (or around 52 persons per day) from 2007. Among them, 60% are children and predominantly girls.



¹⁷⁹ Bangkok Post 12 Dec. 2014; GenderStats, 2014.

¹⁸⁰ Office of the National Economic and Social Development Board, 2013.

¹⁸¹ Center for Health Policy Studies and Center for Health Law, Mahidol University, 2013.

¹⁸² Dr Narong Sahamethapat, Secretary General of Ministry of Public Health, in an address during International Women's Day, 8 March 2014.

¹⁸³ Bangkok Post, 12 Dec. 2014.

As much as 88% of sexual violence victims are adolescent girls aged 10–18 years old, with 72% cases classified as sexual abuse – and some cases of unwanted pregnancy. And 21% of cases involved physical abuse. In the majority of cases, victims know the offender, who may be a relative, friend or boyfriend. Violence tends to occur at home, either in the offender's home or the victim's home. There are also increasing reports of commercial sexual exploitation of children and adolescents in the tourism industry.¹⁸⁴

Sexual abuse of boys is less often reported and therefore more difficult to prosecute. Referring to an ongoing case in which a respected monk in the community was alleged to have sexually abused three novices in the temple, Supensri Pungkoksung, head of the Gender Equality Promotion Centre, explained, “When we helped the boys’ parents file the charges against this monk, we ran into pressure from the community. People did not believe us.” They all said the monk would not do that because he was a good person, she added. “Even the boys’ parents were reluctant. But I told them that they had to do this to keep nurturing the religion, and they agreed.”¹⁸⁵

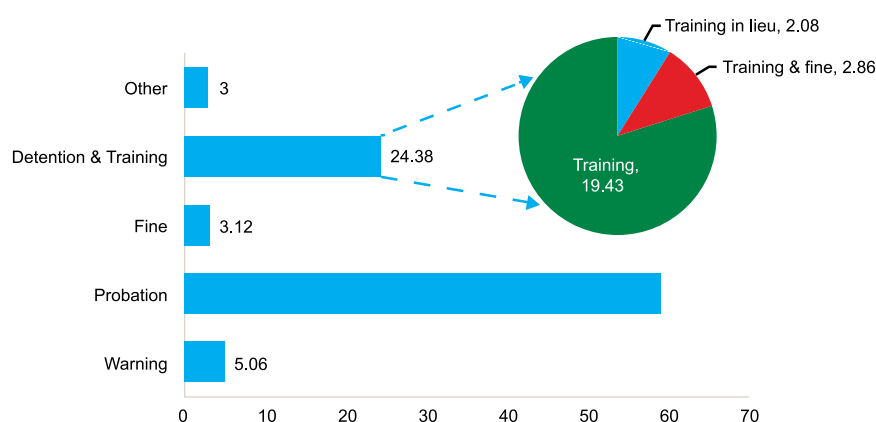
Adolescents in conflict with the law

The Department of Juvenile Observation and Protection handled 36,537 cases in 2014 – a slight reduction from 2013. Most cases involved adolescent boys aged 15–17 years. Only 4.4% of cases were adolescent girls. Most of the young offenders were Thai (98.2%). And 17.5% of adolescents were repeat offenders. Older adolescents were more likely to be repeat offenders than younger adolescents. Drug offences were the most common (at 45%), followed by theft (at 20%), attempted theft, snatching, robbery, blackmail fraud or receiving stolen property. Offences of ‘life and body’ accounted for 10% and sexual offences for 4% of all cases in 2014.¹⁸⁶ Of the 29,643 juvenile cases adjudicated by the Juvenile and Family Court, approximately 60% were sentenced to probation. In 24% of all cases, a young person was sentenced to training in the Juvenile Training Centre, while a warning was given in 5% of cases and a fine was assessed in 3% of cases. Approximately 18% of cases were repeat offenders.

The revised Criminal Procedural Law has established child-friendly investigation procedures. However, implementation is uneven because the coordination and quality of services provided by the multidisciplinary teams lack human and financial resources. Depriving adolescents of their liberty is, in principle, considered a last resort option. Putting this principle into practice is still a major challenge. There is limited availability of appropriate services and mechanisms for rehabilitation and reintegration of young offenders during and after diversion. Even though no foster care services are available, there are some examples of child sponsorship through faith-based organizations. Networks with vocational schools, factories and other businesses for apprenticeship training have been set up on a trial basis as alternatives to detention and training.¹⁸⁷ The Department of Juvenile Observation and Protection has been dependent on funding from the Thai Health Promotion Foundation to support these pilot projects. The sustainability and success of these alternative programmes needs to be closely monitored.

Because correctional training and probation is not working, the Department of Juvenile Observation and Protection is working to keep juveniles out of the correctional training facilities with prevention efforts through schools and through diversionary sentencing (see *Figure 18*). The prevention effort through schools involves the placement of child and adolescent psychologists in schools to provide counselling and cognitive behavioural therapy to students at risk. The goal is to prevent offences before they happen. Diversionary sentencing includes placement in foster care, either in foster families or placement with vocational and technical schools or factories and other workplaces.

Figure 18. Percentage of juvenile convictions, by judgment or court order, 2014



Source: Information Technology Centre. Department of Juvenile Observation and Protection, 2014.

¹⁸⁴ See <https://www.defenceforchildren.nl/images/13/2817.pdf>.

¹⁸⁵ *Bangkok Post*, 12 Dec. 2014.

¹⁸⁶ See the section on alcohol, drug and substance use for additional information on the top-five categories of illicit drugs and substances used in the annual report on case statistics (Department of Juvenile Observation and Protection, 2014).

¹⁸⁷ Interview with Dr Kattiya Ratanadilok, Chief of Research and Development Sector, Department of Juvenile Observation and Protection, 23 Nov. 2015.

Adolescent labour

The minimum age of employment in Thailand is 15 years, and no child younger than 18 (15–18 years) may be employed without informing the labour authority. Employees younger than 18 years are not allowed to work between the hours of 10 p.m. and 6 a.m., work overtime, work on holidays, be employed in hazardous occupations or do work other than prescribed by law. Despite the law, children and adolescents in Thailand continue to engage in child labour in agriculture, including in the shrimp and seafood-processing sector. The worst forms of child and adolescent labour involve commercial sexual exploitation.

Adolescents in Thailand are engaged in labour in agriculture, including in the shrimp and seafood-processing sector. Shrimp and seafood processing occurs in the central, eastern and southern coastal regions of Thailand. Adolescents prepare shrimp or fishponds, feed and maintain the stock, sort fish, remove the heads of shrimp and fish, peel shrimp or remove blood vessels and bones from fish in factory lines and freeze and weigh processed fish or shrimp. The majority of adolescent labourers in this sector are between the ages of 15 and 17 years, with slightly more girls working than boys.¹⁸⁸ Adolescent labour in the shrimp and seafood-processing sector is predominant among migrant children, many of whom come from Myanmar, Cambodia and the Lao People's Democratic Republic, but it is also found among Thai children in the southern provinces.¹⁸⁹ Only one quarter of adolescent labourers in shrimp and the seafood-processing industry were aware of child labour laws, and nearly 65% of adolescent workers did not have a labour contract.¹⁹⁰

An International Labour Organization study in 2012 on child labour conducted in four seafood-producing provinces established an average prevalence rate of 10% in the 5–17 age group. In Samut Sakhon Province, one of the biggest seafood-processing hubs in Thailand, the prevalence rate was highest, at 12.7%. Of the adolescent labourers aged 15–17 years identified in the survey, 36.2% were found in hazardous labour conditions, indicating a need for improved protection for young workers. The survey also uncovered other non-fishing-related industries using adolescent labour, including agriculture (rubber plantations, farming), services, domestic work and assisting in small informal family processing or manufacturing businesses. To date, however, there has been no comprehensive survey of adolescent labour in Thailand. The prevalence of adolescent labour rises when adolescents in the informal sector and unregistered migrant children are included.¹⁹¹

In a 2015 report,¹⁹² Terre Des Hommes estimated that 6,000–8,000 children younger than 15 years were employed in Thailand's shrimp-processing industry, as well as 20,000–30,000 adolescents between the ages of 15 and 17. Children and adolescents in this industry often work more than ten hours a day, six days a week. Working hours – and the wages – are dependent upon the number of the company's orders. Most of the young workers are from migrant families and enter the workforce at age 14 or 15, although some begin working at age 7 years. Few have work contracts. Around 80% of working children want to augment their family's income with their wages. Many families are trying to save money to start up a livelihood in Myanmar.

In May 2014, the Government took actions to address child and adolescent labour. Thailand made changes to its legal framework to raise the minimum age for agricultural work from 13 to 15 years and for work on sea fishing vessels from 16 to 18 years. It also created a national policy committee to improve policy formulation, interagency coordination and implementation to reduce undocumented migrant workers and human trafficking. In addition, the Government has funded multiple programmes aimed at eliminating the worst forms of child and adolescent labour.¹⁹³

Media consumption and communication

In 2015, approximately 24.6 million of the population aged 6 years and older are Internet users in Thailand, representing a share of 39.3% of the population.¹⁹⁴ Adolescents aged 19 or younger were estimated to account for one third (approximately 8.4 million users) of all Internet users.¹⁹⁵ Adolescents 19 or younger spent an average of 41.4 hours a week on the Internet.¹⁹⁶ A Smartphone is the most popular way to access the Internet. Facebook and LINE are the most popular social applications in Thailand (see Figure 19).¹⁹⁷

¹⁸⁸ ILO, 2013.

¹⁸⁹ *ibid.*

¹⁹⁰ Asia Foundation and ILO, 2015.

¹⁹¹ Bureau of Democracy, Human Rights and Labour, 2013.

¹⁹² Terre Des Hommes, 2015.

¹⁹³ Bureau of International Labour Affairs, 2015.

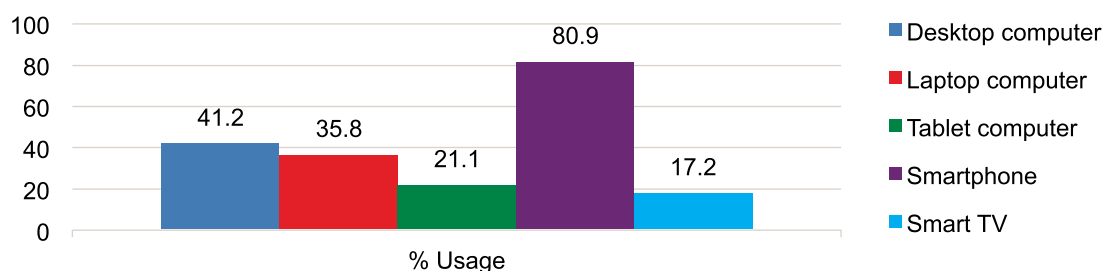
¹⁹⁴ NSO, 2015.

¹⁹⁵ *ibid.*

¹⁹⁶ ETDA, 2015.

¹⁹⁷ *ibid.*

Figure 19. Devices that adolescents use to access the Internet



Source: ETDA, 2015.

According to a national survey conducted by the Rajanakarindra Institute in 2014, between 10% and 15% of children said they were heavily addicted to online games, LINE and Facebook. This is equivalent to approximately 2.7 million youths. Compulsive game addiction is a modern-day psychological disorder falling within the obsessive-compulsive disorder spectrum. Thai adolescents play games for between two and ten hours a day. They spend an average 764 baht playing games and 486 baht on food and snacks during their game playing each month.¹⁹⁸ Game cafes are the most common places for adolescents to play online games. The number of registered cafes increased exponentially from 16,369 cafes in 2008 to 42,853 in 2010 cafes. According to Professor Chanvit Pornnoppadol from Siriraj Hospital, game addicts exhibit aggressive and/or violent behaviour towards their parents or themselves if they are not allowed to play games. Game addicts have a tendency to skip classes and stay up late at night to play games, which in turn leads to poor academic performance and anti-social behaviour.¹⁹⁹

Missing adolescents

A serious concern regarding missing children is that they end up being trafficked. In Thailand, human trafficking is a highly lucrative business, more so than the drug trade.²⁰⁰ The Missing Persons Management Centre run by the Thai police uses the missing persons database set up by the Mirror Foundation in Bangkok. It collects and analyses data to support investigations into missing people. It receives about 30 missing persons reports a month, and 70% of these are solved, one way or another. Their data show that from 2003 to 2015, there were 1,862 reported cases of missing adolescents (349 males and 1,513 females).²⁰¹ Cases of missing adolescents make up more than 29% of the total reported missing person cases and 81% of these cases are adolescent females (see Figure 20).



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¹⁹⁸ Pongyeela, 2010.

¹⁹⁹ Fernquest, 2013.

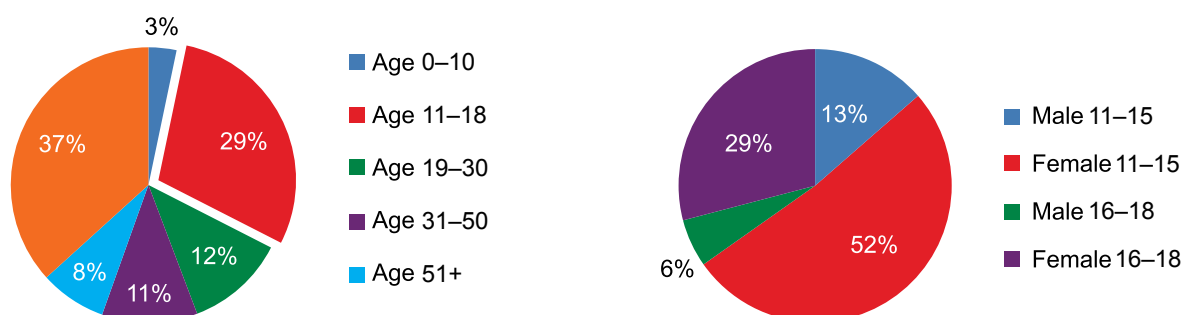
²⁰⁰ See www.soschildrensvillages.ca/thailand-lacks-effective-structure-tracking-missing-children.

²⁰¹ Data compiled from the Center for Missing Persons, see backtohome.org.

Figure 20. Adolescents aged 11–18 years reported missing, by age, 2003–2015

Total persons reported missing in 2003–2015, by age

Adolescents 11–18 years old reported missing in 2003–2015, by age and sex



Source: Database Centre for Missing Persons for Anti-Human Trafficking, Mirror Foundation.

Adolescents have reported engaging in risky behaviours online, such as sharing their photos with strangers, setting their status to 'public' and sharing personal information with websites thus putting themselves at risk for abuse and exploitation. Most cases of missing children are children and adolescents who run away from home. Some of them reportedly had escaped domestic violence; others, predominantly adolescent girls, were lured by strangers they met through social media. Children are often lured by strangers who talk to them and ask them to get into a car. This method accounts for 90% of all missing children.²⁰² The United Nations Office for Drugs and Crime has collected data on online sexual exploitation.²⁰³

In 2011, the Thai police started sharing the Mirror Foundation's database of missing people. This database was designed to act as the central data source for sharing information about missing people in Thailand. However, there is a second database of missing persons run by the Central Institution of Forensic Science within the Ministry of Justice. Thus, there are two separate, unlinked databases of missing persons and unidentified bodies.

In May 2015, the Mirror Foundation and True Corporation launched ThaiMissing, an application for iOS and Android phones. The application shows pictures and standard information of missing people. If users spot someone who fits the description, they can take a picture, indicate the location and report the information directly via the application. In addition to reporting on missing people on the list, users can input data about people suspected to be missing.²⁰⁴

Bottlenecks and barriers

The following summarizes the main bottlenecks that prevent adolescents from being protected from violence.

Social norms tolerate high levels of violence, including sexual violence: Bullying and discrimination perpetrated by students and teachers is unacceptably high and leads to many negative outcomes for targeted students, including dropping out of school and depression. Many school environments are unsafe. Adolescent girls are the major victims of sexual violence. There is social silence surrounding sexual violence, especially when the perpetrator is a respected member of the community.

Weak enforcement of child labour laws: Thailand remains weak in its enforcement efforts regarding child and adolescent labour, particularly in the fishing, agriculture, manufacturing and home-based business sectors as well as in the informal sector. The Government also lacks nationwide data on child and adolescent labour, which impedes the effectiveness of policies and programmes.

Weak enforcement of criminal law around sexual exploitation and human trafficking due to corruption: Criminal law enforcement is hampered by systematic bribery and corruption, with law enforcement officials involved in brothels or karaoke bars, including those purchasing sex with underage girls; these officials are also believed to be involved with human smuggling networks.²⁰⁵

²⁰² OPP, 2014.

²⁰³ See www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_20/Thematic_Discussions/Asian-Group_Thailands-response_Savestanan.pdf.

²⁰⁴ The Nation, 2015.

²⁰⁵ Bureau of International Labour Affairs, 2015.

Social and cultural beliefs and practices around gaming and Internet addiction: Social Internet and game addiction are not seen as a serious problem by parents and caregivers. There is the belief that the addiction will disappear as their children get older. The government policy response is aimed mainly at reducing the number of adolescents in game cafes, but it does not prevent adolescents from playing games at home or a friend's home. Adolescents generally lack the skills to assess the impact of gaming on their life.

Weak coordination in forensic affairs: Because someone going missing is not a crime in Thailand the Missing Persons Management Centre authorities are often slow to take serious action, or they may initiate action only when they suspect that a missing person may be the victim of a crime. Time and coordination are the two most serious factors affecting the ability of national bodies to track down and identify missing persons. Currently, there are two separate databases of missing persons and unidentified bodies. One is the four-month-old Missing Persons Management Centre, which comes under the Royal Thai Police. The other comes under the Central Institution of Forensic Science, under the control of the Ministry of Justice. The two databases are not linked.



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Chapter 7. Vulnerable groups of adolescents

This chapter provides an overview of the main groups of vulnerable adolescents in Thailand and the types of obstacles they face. Despite their young age, many of them face multiple deprivations and any successful interventions focusing on this age group must pay attention to these vulnerable young people. Gender, ethnicity and nationality are some of the key indicators of stigma and discrimination in this overall group.

Married adolescents and adolescent mothers

Until recently, young people could legally marry at age 17 years without the consent of their parents or as young as 13 years with parental consent. Current Thai law sets the minimum age for marriage at 17. For anyone younger than 20 years, written parental consent is now required. The law applies to both boys and girls, but the practice overwhelmingly affects girls.

Child marriage is a factor leading to adolescent pregnancy.²⁰⁶ A 2015 UNICEF study report noted that marriage among adolescents is both a cause and consequence of pregnancy.²⁰⁷ Within traditional Thai norms, childbearing out of wedlock is not acceptable. Thai women are educated to keep away from the opposite sex and to behave according to tradition. Young women are to be virtuous and well behaved. In Thai society, a young woman's virginity is an important virtue, and traditionally the age at marriage is considered a marker of sexual debut. A pre-marital sexual relationship that leads to an unplanned pregnancy is considered a serious 'loss of face' even today.²⁰⁸ Therefore, pregnant young women are married to a partner to 'save face' or to avoid legal complications.²⁰⁹ Early sexual debut and unplanned pregnancy often are contributing factors to child marriage.

The higher rates of marriage or partnership among females aged 15–19 years are found in six provinces – Chai Nat, Prachuap Khiri Khan, Phang Nga, Rayong, Samut Sakhon and Uthai Thani. Three of these provinces also have recorded the lowest levels of education among women.²¹⁰ Data from the MICS 4 indicate that around one in six young women aged 15–19 is currently married or in a union (at 16.3%). Geographically, early marriage prevalence is highest in north-eastern Thailand (at 18.4%) and lowest – though still high – in Bangkok (at 12.3%).

Education is a protective factor for early marriage. More than half of young women with only a primary school education (58.7%) are currently married, compared with 2.2% for young women with a secondary education or higher. Socio-economic factors also contribute to early marriage. The disparity between early marriage among the poorest young women and the richest young women is large (21.3% and 4.7%, respectively).²¹¹ The MICS 4 findings found that a larger proportion of poor women were married before the age of 18 (at 21.2%), compared with rich women (at 7.5%) (see Figure 21).

Data strongly suggest that delayed marriage is related with educational continuation. Adolescents who delayed marriage lived in urban centres and had higher levels of education. Early marriage is most common in rural areas and among the very poor. Poor parents may consider marriage to be a way of protecting and providing security for their girls and for themselves. The data therefore confirm that despite overall trends showing an increase in the age of marriage early marriage is a reality for the most vulnerable young women in rural areas and those living in the North-East of Thailand.



206 UNFPA, 2013.

207 UNICEF, 2015.

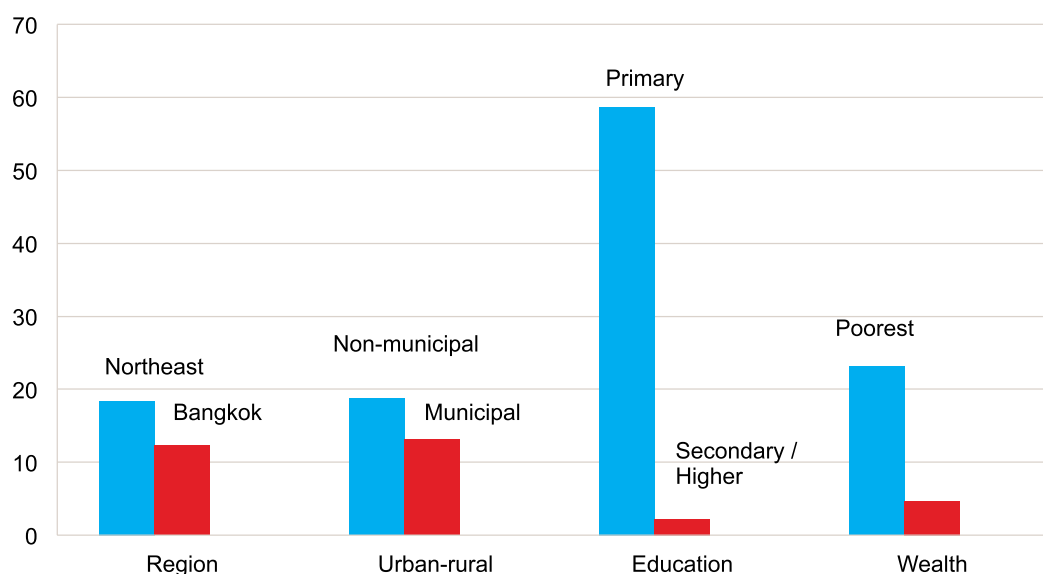
208 Ounjitt, 2011.

209 UNICEF, 2015.

210 UNFPA, 2013.

211 NSO, et al., 2013.

Figure 21. Percentage of women aged 15–19 who were married before age 18, by region, location, education and household wealth



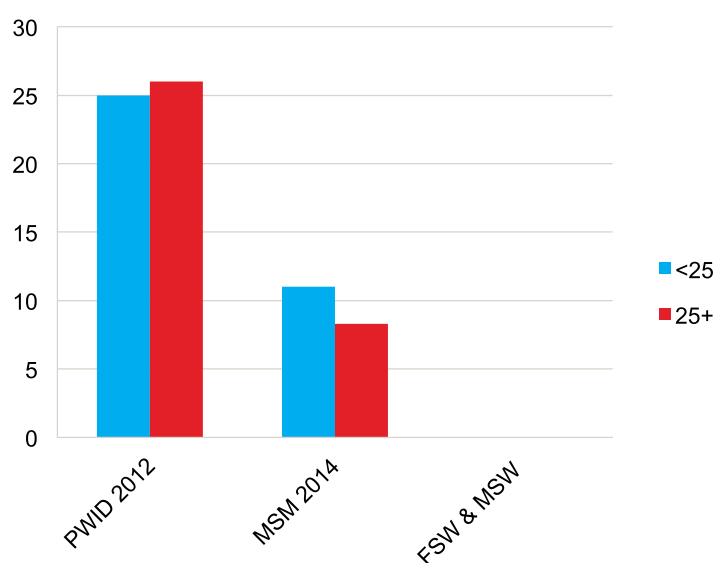
Source: Multiple Indicator Cluster Survey 2012 (MICS 2012)

Young key populations at risk of HIV infection

Young key populations are people between the ages of 10 and 24 years who are most likely to be exposed to HIV or to transmit it (see Figure 22). A media report in 2014 noted that new infections were rising among young people engaging in high-risk behaviours, such as trading sex, injecting drugs and unprotected sex between young men.²¹²

There are an estimated 11,000 adolescents aged 10–19 years living with HIV (5,300 young men and 5,700 young women).²¹³ An estimated 1,700 adolescents, aged 15–19, were newly infected with HIV in 2013. The number of new infections among both sexes is relatively equal (fewer than 1,000), with 48% of new HIV infections occurring among adolescent girls. Between 2004 and 2014, the annual rate of new HIV infections among adolescents aged 15–19 fell substantially. The estimated number of AIDS deaths among adolescents was fewer than 500.²¹⁴

Figure 22. HIV prevalence among key populations



Source: UNAIDS, 2013 (HIV estimates).

²¹² Herman, 2014.

²¹³ *ibid.*

²¹⁴ UNAIDS, 2013.

HIV prevalence among young men who have sex with men (MSM) (younger than 22 years) ranges from 8.8 to 12.2 per 100 person years. The estimated HIV incidence among urban young MSM (aged 15–22 years) almost doubled from 4.1 to 7.6 per 100 person years between 2003 and 2014. The HIV prevalence among young MSM (younger than 25 years) in 2014 was higher than among older MSM (older than 25 years), at 11% and 8.3%, respectively.²¹⁵ These data are alarming and a cause for concern. Information on the prevalence of HIV among female and male sex workers in Thailand is unavailable.

Reducing the sexual transmission among MSM, transgender persons, male sex workers and female sex workers remains a top priority for Thailand and is addressed in the Ending AIDS Operational Plan. However, consistent condom use among young MSM has stagnated, at 50%, and HIV testing in 2013 remained at 27%.²¹⁶ Only 54% of people who inject drugs, 27% of MSM and 40% of female and male sex workers younger than 25 years know their HIV status.²¹⁷

Overall, the uptake of prevention and HIV testing and counselling services has increased slowly, although service coverage has not reached optimal levels, and prevention programmes will not achieve the national targets. As many as 49% of MSM and 48% of female sex workers younger than 25 years were reached by HIV prevention programmes in 2014.²¹⁸ Progress has been made in reaching venue – based female sex workers but outreach to non-venue-based female sex workers is still limited. Services need to adapt to the local context and address specific needs across the spectrum of MSM groups and other vulnerable sub – groups to increase service utilization.²¹⁹

Adolescent migrants

The actual number of foreign nationals living in the country is unknown. The most recent estimate was 3.7 million in 2013. The estimated number of workers from Cambodia, the Lao People's Democratic Republic and Myanmar was 2.7 million: 1.1 million with work permits and 1.6 million without.²²⁰ The registration of migrant workers at the One-Stop Service Centres countrywide (26 June to 31 October 2014) indicates that there were 92,560 children aged up to 15 years who accompanied their parents to Thailand (40,801 Myanmar, 42,609 Cambodian and 9,150 Lao).²²¹ The Department of Labour Protection and Welfare estimated that there were 510,000 young migrants aged 15–18 years with a work permit in 2011.²²² However, there are no estimates for unregistered adolescent migrants who often work in hidden or marginal jobs.

Retrospective data on the age that migrants first came to Thailand show that between 23% and 31% of them came when they were younger than 18 years (see Table 4).²²³ Adolescent migrants therefore make up a sizeable portion of the migrant population in Thailand.

Table 4. Adolescent migrants who first came to Thailand, by country of origin and sex (percentages)

	Myanmar			Cambodia			Lao PDR		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Younger than 12 years	2.4	1.2	1.8	1.7	1.8	1.8	2.6	2.9	2.8
12–14 years	3.9	3.4	3.7	2.6	4.5	3.1	64.6	6.6	5.7
15–17 years	18.2	16.1	17.2	18.0	17.2	17.8	19.6	24.8	22.5
Total younger than 18 years	24.5	20.7	22.7	22.4	23.5	22.7	26.8	34.3	31.0
(N)	(1,216)	(953)	(2,169)	(541)	(257)	(798)	(151)	(287)	(438)

Source: United Nations Thematic Working Group on Migration in Thailand, 2014.

Despite the open educational policy allowing migrant and stateless children to access basic education, the 2012 MICS data showed that only an estimated 82% of non-Thai children attended primary school. There are no data on secondary school attendance for non-Thai adolescents. The low education access of migrant children is due to both institutional and socio-cultural factors. Socio-cultural factors include hostile attitudes of some school managers towards migrant and stateless children, resulting negative attitudes towards Thai schools in some migrant communities, lack of self-esteem among migrant children and a lack of understanding of the value of education among migrant parents and frequent moves because migrant parents are in search of work resulting in their children dropping out of school.

²¹⁵ UNICEF et al., 2015.

²¹⁶ National AIDS Committee, 2015.

²¹⁷ UNICEF et al., 2015.

²¹⁸ UNAIDS, 2013.

²¹⁹ National AIDS Committee, 2015.

²²⁰ *ibid.*

²²¹ Information from Bureau of Registration Administration, Department of Provincial Administration, Ministry of Interior.

²²² UN Thematic Working Group on Migration in Thailand, 2014.

²²³ *ibid.*

Access to health care

Migrants have access to health insurance through either the social security scheme or the newer migrant health insurance scheme. In a historic move in August 2013, the MOPH announced that health insurance would be extended to cross-border migrant workers who are not covered by the social security scheme, including both registered and unregistered migrants from Myanmar, the Lao People's Democratic Republic and Cambodia.²²⁴ The policy includes benefits such as family planning, health examinations, including HIV testing²²⁵ and pre- and postnatal care for pregnant women; delivery care; neonatal care until 28 days of age; prevention of parent-to-child transmission of HIV and, for the first time, antiretroviral treatment.²²⁶ As of 30 September 2014, the number of migrants who registered with the migrant health insurance scheme was 1,423,831.

Theoretically, registered adolescent migrants have access to health care.²²⁷ In reality, however, the number of health care providers offering health insurance is limited, and they are difficult to identify. Some hospitals are still reluctant to sell migrant health insurance for fear of incurring net losses or administrative procedures. Consequently, access to prevention and care services for HIV and tuberculosis are still limited for migrants.²²⁸ Language barriers make understanding the registration system difficult, frustrating both health care providers and migrant workers. In addition, barriers for young people may also include a greater likelihood of having restricted autonomy to seek health care because they work long hours or they may feel intimidated by their employers. They also have limited experience in addressing health issues and caring for themselves. Unregistered migrants are in an even more precarious situation. Fears of job loss and interactions with the Ministry of Labour, police and immigration authorities who are not supportive to positive health-seeking behaviour among undocumented migrants.²²⁹ leave migrants vulnerable to arrest or harassment by local authorities when they go to public hospitals or seek transportation to local clinics.²³⁰

Employers continue to be one of the main reasons why migrant women are unable to attend health services. This is particularly evident for pregnant migrants. Employers will deny women the opportunity to visit a hospital or clinic threatening termination from work. Even though all female workers in Thailand are entitled to 45 days of paid maternity leave, migrant women almost never receive this benefit.²³¹ The Government has repeatedly threatened to deport pregnant migrant women.²³²

Adolescent migrants are also at risk of HIV infection. Migration is not a risk factor for HIV, but it does increase conditions that contribute to vulnerability. Adolescent migrants may face limited rights due to their legal status as non-citizen and their age. They have entered an environment in which they are removed from traditional social controls – family, community, culture – and are in the prime of their reproductive years. Migrants in general have limited access to information and services due to language barriers and restrictions on mobility. In addition, lack of knowledge and sub-culture norms may encourage young migrants to engage in behaviours that increase the risk of an STI or unplanned pregnancy. The reported HIV prevalence among young migrant workers in six provinces of Thailand in 2010 was 1.1% (see Table 5).

Table 5. HIV prevalence among migrant workers in six provinces

	Male	Female	Total
Age 15–24 years	1.0%	1.4%	1.1%
All ages	1.7%	2.1%	1.9%

Source: Bureau of Epidemiology, MOPH, 2010.

²²⁴ National AIDS Committee, 2015.

²²⁵ Migrants testing positive for HIV are protected by the following legislation: Code of Practice on Prevention and Management of HIV/AIDS in the Workplace, 2005, Department of Labour Protection and Welfare. The Code prohibits discrimination in employment on the grounds of HIV status (section 5.1.1). The Code is not legally binding, however, being that it is a set of guidelines rather than a legal document. Immigration Act 1979: prohibits the entry of migrant workers from other countries with prescribed diseases. Section 12: "Aliens that fall into any of the following categories are excluded from entering into the Kingdom."

²²⁶ IOM, 2013.

²²⁷ UN Thematic Working Group on Migration in Thailand, 2014.

²²⁸ National AIDS Committee, 2015.

²²⁹ *ibid.*

²³⁰ UNICEF, 2011.

²³¹ Women can take maternity leave for up to 90 days. The employer is to pay the first 45 days, commensurate to the wages of a normal workday (Labour Protection Act, section 59). Those women who are contributing to the Social Security system receive payment from the Social Security system for the latter 45 days as well, although migrants rarely receive social security benefits, even if they are contributing to the system.

²³² MAP Foundation, 2014.

Bottlenecks and barriers

The following summarizes the main bottlenecks preventing pregnant adolescents or adolescent mothers from fully enjoying their rights.

Social norms and social stigma: Pregnant adolescents and adolescent mothers suffer from social stigma and exclusion, sometimes even within their family. Adolescent girls bear the brunt of the consequences from getting pregnant – with little or no impunity for the baby’s father.

Inadequate services for adolescents: Current social services are inadequate in terms of availability and in terms of capacities, although improvements have been made.

The following summarizes the main bottlenecks that prevent adolescents at risk of contracting HIV from receiving appropriate health care.

Social norms and stigma: “LGBT may not want to get tested because a positive test result means they will have to disclose the result to their parents. But parents will want to know how their child got infected and have many questions. It is just too difficult to disclose HIV status and sexual behaviour at the same time,” reported an adolescent key informant.

Inefficient guidelines around HIV treatment for minors: Although new clinical guidelines for HIV testing and counselling for persons younger than 18 no longer require parental consent, it is still necessary for access to HIV treatment or other health services. At the same time, service providers are hesitant to provide services to adolescents without legal protection of the law or a regulation.

Inadequate services for adolescents: Service providers at HIV testing facilities and others lack the skills to discuss sensitive issues with adolescents.

And the following summarizes the main bottlenecks that prevent migrants from receiving appropriate health care.

Lack of information: The majority of migrants are unaware of their legal rights and therefore easily become the victims of discrimination and abuse. Health-seeking behaviours are not encouraged by Thai authorities, even though legally they are entitled to it. The complaint mechanisms for migrant workers who cannot speak and read Thai and for those in the informal sector and in remote areas, including on fishing vessels, remain weak.

Legal gaps: Several adolescent migrants cannot access health care services due to their lack of legal status in Thailand.



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Chapter 8. Discussion

The adolescent situation in Thailand

The situation analysis of adolescents in Thailand presents a picture of a high-middle-income country characterized by lagging economic growth, demographic change and rising inequity between rural and urban settings. Thailand is now an ageing society, which has important consequences for stimulating and sustaining economic growth in the future. The share of the economically active population has reached its peak and is now shrinking, making investment in today's adolescents ever more important. The lagging birth rates and the higher costs associated with taking care of older persons will have profound impacts on the provision of social services. Demographic change as well as a change in lifestyle has led to a rise in non-communicable diseases, which are responsible for 70% of all adult deaths in Thailand. The main risk factors leading to non-communicable diseases are tobacco use, alcohol use, high blood pressure and obesity – all behaviours that have their onset in adolescence and early adulthood.

Enormous national efforts have poured into levying taxes on alcohol and tobacco, banning the advertising of alcohol and tobacco products, limiting sales of cigarettes and alcohol to minors and on banning smoking in public places.

In addition, national campaigns to support physical activity were recently launched with support from members of the Royal family. However, complementary health education programmes have not kept pace over recent years evidenced by the large percentage of adolescent boys and girls who start smoking and drinking in their mid-teens. A sizable proportion of adolescent boys experiment with illicit drugs. Marijuana and methamphetamines are the most commonly used drugs in this age group. There are also reports of game addiction linked to the obsessive consumption of online gaming among adolescent boys in Internet cafes. Smoking, drinking, using drugs and addictive gaming are behaviours more common in adolescent boys. Rigid gender norms and idealized masculinity put adolescent boys at risk of violence, aggressive driving and unprotected sexual intercourse.

For girls, the behaviours are exactly the opposite. Thai culture teaches adolescent girls to be reserved, naïve and inexperienced in sexual matters, placing them at great risk of being the victims of violence, exploitation and abuse. In relation to sexuality, many Thai women must navigate ancient Thai customs while embracing globalized popular culture. Many Thai adolescents are often caught between the two worlds.

Delayed marriage, premarital sexual activity and inadequate sexuality education contributed in some part to the high adolescent birth rates experienced in the past decade. Pregnant adolescents face numerous barriers, including a high degree of social stigma and the potential risk of complications from clandestine abortions. An estimated 200,000 to 300,000 adolescent girls seek abortions each year.²³³ Government programmes have started to respond by expanding access to adolescent-friendly services in district hospitals, by training health service providers and by strengthening school-based sexuality education. A 2015 review of the implementation of comprehensive sexuality education in Thai schools found that aspects (but not the full range of topics) in the curriculum are taught in most schools, according to reports from teachers and students. However, there is also indication that sexuality education suffers from a lack of support from school principals and teachers. Moreover, some students hold negative attitudes about gender equality and violence, which underscores that much more work needs to be done.

There are other vulnerable groups, for example, young MSM, migrants, stateless people and ethnic minorities living in the North and the South of the country. The social stigma associated with membership in one these groups can have a devastating effect on a range of social indicators. Young migrants and stateless people live in constant fear of losing their jobs and of being deported. Therefore, making use of health care and education services becomes a luxury. Young MSM and other members from key affected populations are associated with a rise in HIV incidence and this after years of decline.

The education sector has measured tremendous success in terms of primary school enrolment over the past three decades. However, secondary school attendance has declined to about 80%. Access and quality of education is extremely variable across the country. Academic standards in Bangkok are simply not comparable to those in rural village schools. This and other factors have kept academic performance indicators stagnating over the past decade.



²³³ UNFPA, 2014.

Other factors include the proliferation of poor-quality village schools, inadequately trained teaching staff (especially in rural areas) and insufficiencies in education sector financing.

Multiple reports have offered recommendations on how to restructure the education sector. Upfront is the need to address the skills mismatch. The mismatch between the output of the educational system and the demands of the labour market may be attributable in part to poor planning, but it is also a function of the country's rate of change. Two decades ago, it would have been hard to anticipate the shift to skill-based industries and services. As an open, middle-income economy, Thailand needs the ability to adjust its labour profile in response to shifting demands. That requires more extensive facilities and support for retraining – in technical skills, workplace skills and language. Low-skills jobs are being taken over by young migrant workers from neighbouring countries.

Amid all the change, the Government is trying to keep pace by building supportive social structures to assist adolescents and young people. The Department of Children and Youth within the Ministry of Social Development and Human Security is responsible for formulating and coordinating youth policy across government ministries and agencies. The DCY took leadership for developing the National Child and Youth Development Plan 2012–2017. With proper support, the DCY role could be strengthened to make it an important partner and advocate for adolescent development. Other positive factors include Thailand's potential role to assume regional leadership for adolescent development. Thailand was a forerunner for economic and social development for many years, based on its strategic location and the presence of multiple United Nations agencies and international organizations. Thailand also has an active and powerful civil society movement, which could be tapped further as a resource and partner.

UNICEF should support the DCY in gathering all strategic partners around one table to discuss planning and implementation for the coming years. The most important resource, however, are Thailand's children and adolescents. Planning for – and with – eight million bright young minds will have critical impact on the future of adolescent development programming in the country.

Bottleneck analysis

The biggest challenge in creating a profile of Thai adolescents is the lack of data collected in a format that might be disaggregated by age, sex and other variables, such as immigration status, ethnicity, geographic location and education. Different age categories and definitions (child, adolescent, young person, youth) overlap, causing disjointed data systems. The situation calls for alignment of definitions, data and indicators in routine data collection systems. In addition, the Thai adolescent population has not historically been surveyed as a population, with children younger than 15 years assessed in one study and the remainder of the adolescents being grouped with adults (aged 15–49 years). Sometimes, data may be reported for youth (15–24 years) but with little consistency. More efforts from departments within multiple ministries are required to collect data on the entire spectrum of ages within range of 10–19 years because adolescence is a unique and prime target population for reform in development programmes. The confusion surrounding definitions may be one reason why adolescents are virtually invisible in national financing plans and budgets. This presents a huge gap.

In terms of the legal framework for this needed reform, Thailand has ratified several important international legal instruments, including the Convention on the Rights of the Child in 1992. The 2007 Constitution was hailed as the 'people's Constitution' because it guaranteed many fundamental human rights, including many protections for adolescent rights. However, this and an interim Constitution of 2014 were repealed in 2008 and 2015, respectively. Thailand now operates under another interim Constitution. The political volatility, unfortunately, prevents cohesive administrative efforts from implementing policies and ensuring consistent enforcement.

Drawing attention to additional legislative oversight, there is a series of glaring mismatches in the ages of consent and access to treatment in sexual health care for adolescents. The age of consent for sex is 17 years, but the age at which adolescents can access sexual and reproductive health services is 18. The age at which an adolescent can marry is 17 years, but they cannot be tested for HIV nor receive treatment without parental consent before the age of 18. It is obvious that the average age that Thai adolescents become sexually active vastly precedes the age they have legal empowerment to access sexual and reproductive health services. Not to mention the numerous other discrepancies between formal, religious or customary law on the minimum age of marriage and other restrictions for sexual behaviour and treatment in some communities.

There is a general lack of coordination concerning adolescent programming. The DCY has an important role within the Government, especially with many other agencies overseeing the different aspects of programming and services for adolescents. Lack of proper monitoring and evaluation systems means that the implementation of some programmes is ineffective or weak. For example, abortion in Thailand is illegal except in special court-approved cases, but with such a huge deficiency in national welfare and judicial infrastructure, thousands of young women suffer through botched back-alley abortions. Administrative incompetence and lack of constitutional enforcement cost these young women their lives. A change in the abortion law and its enforcement in Thailand would ensure the single largest positive change in the health and well-being of adolescent girls in Thailand.

Even in the area of education, in which political commitment and public investment is high, there are structural barriers to measurable and effective reform. Given that 25% of the national budget is allocated to the education sector yet

academic achievement has remained the same for the past decade, there are inefficiencies within education financing. Good education has become a 'big business'. To place children and adolescents in good-quality schools, parents are saddled with the additional costs of uniforms, stationery and special activity fees. There are huge disparities in education quality between rural and urban areas. Rural village schools are understaffed and lack trained teachers. In better-quality schools, teachers are under great pressure to achieve key performance indicators; this leads to vulnerable students being dropped rather than targeted with the support they need. Students are concerned about whether they are being taught the skills that will be required in a widening labour market under the ASEAN Economic Community.

Large numbers of students are excluded or are at risk of being excluded from the school system. These include students with disabilities, rural students, students affected by HIV, migrants and stateless children. There are no special facilities for students with disabilities. Specialized programs are often initiated by other government or non-government agencies and may not be fully sanctioned by the Ministry of Education and thereby never become institutionalized. Few adolescents have access to after-school or recreational programmes, which means that they are left home alone for long periods of time without proper adult supervision.

As Levtoy noted, "In Thailand, gender equality to education – that is, equal access to education in terms of enrolment, for example – has for the most part been achieved, though attention is still needed in particular sectors of the population. The focus now should be on achieving equality within the school system, and perhaps most importantly, in other outcomes through education."²³⁴

Some adolescents view alcohol and tobacco use as a sign of being an adult. While efforts have been stepped up to prohibit underage sales, there is often weak enforcement from both law enforcement and retailers due to social sanction on the use of these substances. Similarly, information on alcohol and tobacco are either not included in drug and substance use curricula or not taught. Adolescents also may be influenced by alcohol and tobacco brand recognition through the sale of other products, such as clothing. Prevention efforts focus on negative messaging, they do not focus on skills development to assess the social and physiological impact of drug use. Substance use prevention competes with other health-related topics (such as HIV and sexual and reproductive health) for time and space in the curriculum.

Internet and game addiction are not seen as a serious problem by parents and caregivers. Students do not want to acknowledge or reveal the symptoms of depression out of fear of stigmatization. Teachers and teacher-counsellors do not always have the training to recognize symptoms of depression in students and do not have the capacity to provide appropriate counselling to assess the level of depression and/or suicidal ideation and have difficulty making appropriate referrals for specialized services. Only a small number of district hospitals have child and adolescent psychologists on staff.

Gender norms and social stigma perpetuate adolescents' ignorance about reproductive health and shared responsibilities in sexual relationships. Adolescent girls are discouraged from seeking information and services about reproductive health while being expected to shoulder the responsibility of pregnancy prevention and the consequences should they get pregnant. Adolescent boys are encouraged through media and peer pressure to increase their sexual prowess and yet typically do not share the burden of pregnancy prevention and parenting. Social stigma against unplanned pregnancies and adolescent sexuality is a barrier to adolescents learning about and/or accessing contraception and other reproductive health services. Adolescents do not have easy access to semi-permanent birth control because it is expensive and not covered by the universal health care system. Negative attitudes and behaviours of teachers, parents and service providers are barriers to adolescents' access to health and social services because they discourage open communication and requests for help. Young MSM, young sex workers and young injecting drug users face multiple barriers in accessing information and counselling, prevention and treatment services.

Gender inequality manifests itself in high rates of violence. Violence is experienced in all domains of an adolescent's life, including school, at home and in the community. Bullying and discrimination perpetrated by students and teachers is unacceptably high and leads to many negative outcomes for targeted students including drop-out and depression. Many school environments are unsafe. Out-of-school adolescents, such as documented and undocumented migrants and stateless young people, live under constant fear due to their precarious legal status and the threat of deportation. The majority are unaware of their legal rights and therefore easily become the victims of discrimination and abuse. One-Stop Service Centres do not have a registration process for migrant children aged 16–18. Children aged 15–18 may claim to be older than 18 through documents that were falsified so they could work in Thailand.

Thailand remains weak in its enforcement efforts regarding child and adolescent labour, particularly in the fishing, agriculture, manufacturing and home-based business sectors. Criminal law enforcement is hampered by systematic bribery and corruption, with law enforcement officials involved in brothels or karaoke bars, including those purchasing sex with underage girls. These officials are also believed to be involved with human smuggling networks.²³⁵ The most tragic example of negligence through bureaucratic mismanagement are the cases of missing children; rivalry and limited cooperation between the actors involved, such as two non-linked databases and the lack of coordination, have left the Government failing miserably to protect the rights of the country's most vulnerable adolescents.

²³⁴ Levtoy, 2014.

²³⁵ Bureau of International Labour Affairs, 2015.

Chapter 9. Recommendations

The vision is for the Government of Thailand and UNICEF to build on and strengthen work that responds to the most important issues affecting adolescents in Thailand. It is recommended that the UNICEF Country Office take a lead role in coordinating interagency work related to adolescent development. UNICEF can leverage its comparative advantage in data collection, as a convener, a sharer of knowledge and in M&E of existing programmes.



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	Education	Health	School to work transition	Social protection	Civic & cultural engagement
UNICEF is to lead	Coordination of the adolescent expert group, data collection, regional knowledge sharing and M&E				
	Quality of education Inclusive education Gender inequality			Missing children and trafficking Adolescents in conflict with the law	Implementation of the CRC Participation Innovation
In partnership with UNAIDS		HIV prevention for young key populations			
In partnership with UNFPA and UNESCO	Sexuality education + parent component	Teenage pregnancy and sexuality education	Technical education and vocational training	Gender-based violence	Extracurricular activities
In partnership with WHO	General health promotion	Non-communicable diseases Mental health			Extracurricular activities
In partnership with WHO and UNFPA		Adolescent-friendly services			
In partnership with ILO	Quality of education – skills mismatch			Child and adolescent labour	Extracurricular activities
In partnership with UNDP					Disaster risk reduction Climate change
In partnership with civil society		HIV prevention for young key populations		Migrant and stateless adolescents	Civic education
In partnership with the business sector	Skills mismatch Innovation/technology for quality education	Sexual and reproductive health and HIV prevention among employees	Vocational training and employment opportunities	Protection from exploitation and abuse in tourism and online	Platforms for participation and engagement

More specifically, there are existing platforms that can be built upon to strategically address some of the gaps outlined in the thematic areas above:

	Education	Health	School to work transition	Social protection	Civic and cultural engagement
ASEAN network for education and other regional networks	Quality of education Inclusive education Gender inequality	Road traffic injuries		Missing children and human trafficking Adolescent migrants and stateless people	
HIV prevention and treatment	Addressing stigma and discrimination through anti-bullying programmes	Improving access to HIV counselling and treatment services			Advocacy to change parental consent laws for accessing HIV counselling and treatment services
Education reform	Quality education Inclusive education Gender equality in education		Skills mismatch		
National Strategy to Prevent Teenage Pregnancy	Comprehensive sexuality education Parent education	Improving quality and access of sexual and reproductive services, especially access to contraception			Advocacy for a change in the abortion law
Emerging issues				Adolescent migrants and stateless people	Adolescents as agents of change U-report
Non-communicable diseases	Education to promote healthy eating, physical education and recreation (play)	School health check-ups			Extracurricular activities to promote physical education and recreation (play)

UNICEF already takes a leading role as facilitator of the adolescent expert group in Thailand. The functionality of the group should be maintained and intensified. It is recommended that UNICEF continues to function in its lead role as convener and coordinator of interagency work on adolescent development. A next step might involve dialogue with relevant agencies about supporting the formation of subcommittees on specific topics, such as teenage pregnancy or non-communicable diseases. Subcommittees could then try to identify and share models of successful adolescent-friendly programmes and other best practice examples in adolescent programming. It is envisioned that these discussions would eventually lead to the piloting of promising programmes. Building on the success of the UNICEF Innovation Unit, the country office could explore the feasibility of using U-Report as a way of consulting with adolescents on current topics and using the mobile platform to send out a variety of broadcast messages. Collaboration with other regional innovation initiatives might be explored.

UNICEF also takes a lead role in data collection on adolescents, as convener of expert consultations for regional knowledge sharing (such as the regional situation analysis on teenage pregnancy) and supporting the monitoring and evaluation of existing programmes (such as the review of the implementation of comprehensive sexuality education in Thailand). The UNICEF role could be strengthened by enhancing support to the DCY in the areas of data collection, policy development and policy advocacy, such as increasing adolescents' visibility in budgets and financing. Important data gaps such as estimates of the number of adolescent migrants, adolescents engaging in hazardous labour and adolescents suffering from violence and abuse, have already been highlighted. Existing surveys could be amended or new studies could be commissioned to address the gaps and support the development of future policy and programmes.

UNICEF should continue to support capacity building of adolescent development specialists in key positions of the Government and among teachers, health providers and other service personnel.

Conclusions

A significant number of the issues facing adolescents relate to the poor deployment of social services and governmental policies. It is obvious that communication and coordination tends to diminish at higher levels of administration, creating competing priorities between agencies. These agencies need to be brought together to develop a common strategy, work plan, goals, objectives and indicators. Funding also needs to be coordinated to reduce the duplication of activities and expenditures. These strategies would offer hope for effective administrative reform, and these measures will be especially critical, given the possibility of governmental stability offered by ratification of a Thai Constitution as well as the upcoming promise of the formal election cycle.

Educational institutions are vulnerable in Thailand, and this situation is perhaps most literally illustrated by the attacks on schools, teachers and students during the conflict in the South. Attention to the health and well-being of the adolescent population of any nation should factor heavily in the drafting and implementation of policies that hope to directly impact the equality and prosperity of the country's social and economic future.

Some critical areas of reform in Thailand have been identified that will greatly impact adolescent development in the coming generation.

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กรมกิจการเด็กและเยาวชน กระทรวงการพัฒนาสังคมและความมั่นคงของมนุษย์ (2558)

รายงานการพัฒนาเด็กและเยาวชน ประจำปี 2557

กรมกิจการเด็กและเยาวชน กระทรวงการพัฒนาสังคมและความมั่นคงของมนุษย์ (2557)

รายงานการพัฒนาเด็กและเยาวชน ประจำปี 2556

กรมควบคุมโรค _กรมอนามัย _กรมสุขภาพจิต กระทรวงสาธารณสุข (2556)

แนวทางการจัดบริการสุขภาพวัยรุ่นแบบบูรณาการตามมาตรฐานกระทรวงสาธารณสุข ฉบับปรับปรุง

กรมควบคุมโรค. กระทรวงสาธารณสุข (2557/2014)

แนวทางการตรวจรักษาและป้องกันการติดเชื้อเอชไอวี ประเทศไทย ปี 2557

กรมพินิจและคุ้มครองเด็กและเยาวชน (2557) รายงานสถิติคดี ประจำปี พ.ศ. ๒๕๕๗

กรมสวัสดิการและคุ้มครองแรงงาน กระทรวงแรงงาน (2558). สถิติสวัสดิการและคุ้มครองแรงงาน พ.ศ. 2557

กรมสุขภาพจิต กระทรวงสาธารณสุข (2555)

รายงานการสำรวจสถานการณ์ระดับสติปัญญา เด็กนักเรียนไทย 2554

กรมอนามัย (2558) รายงานประจำปี กรมอนามัย 2557

กระทรวงสาธารณสุข (2557) ยุทธศาสตร์ ตัวชี้วัด

และแนวทางการจัดเก็บข้อมูล กระทรวงสาธารณสุข ปีงบประมาณ พ.ศ. 2558

กระทรวงสาธารณสุข (2558) คู่มือแนวทางการจัดบริการสุขภาพวัยรุ่นแบบบูรณาการ ตามมาตรฐานกระทรวงสาธารณสุข ฉบับปรับปรุง ครั้งที่ 2

กระทรวงสาธารณสุข (ไม่มีข้อมูล) รายงานผลตามเป้าหมายการพัฒนาแห่งสหัสวรรษด้านสุขภาพ ฉบับที่ 3 พ.ศ. 2557

กองโภชนาการ กรมอนามัย กระทรวงสาธารณสุข (2549) รายงาน

การสำรวจภาวะอาหารและโภชนาการของประเทศไทย ครั้งที่ 5 พ.ศ. 2546

กองโภชนาการ กรมอนามัย กระทรวงสาธารณสุข (2549) รายงานการสำรวจภาวะอาหารและโภชนาการ ของประเทศไทย ครั้งที่ 5 พ.ศ. 2546

กิตติพงศ์ แซ่เจ็ง (2558) สถานการณ์ประชากรและอนามัยการเจริญพันธุ์ (PDF-PPT) สำนักอนามัยการเจริญพันธุ์ กรมอนามัย

คณะกรรมการพัฒนาการเศรษฐกิจและสังคมแห่งชาติ (2558) คนไทยกับสังคมสูงวัยที่มีคุณภาพ

การประชุมกลุ่มย่อยที่ 3 ในการประชุมประจำปี 2558 ของ สคช. ทิศทางแผนพัฒนาฯ ฉบับที่ 12 วันจันทร์ที่ 14 กันยายน 2558 ณ ศูนย์แสดงสินค้าและการประชุม อิมแพ็ค เมืองทองธานี

โครงการ Child Watch Thai (ไม่มีข้อมูล) สภาวะการณ์เด็กระหว่างเด็กและเยาวชนในรอบปี 2554–2555

โครงการประเมินเทคโนโลยีและนโยบายด้านสุขภาพ (HITAP) (2556) รายงานฉบับสมบูรณ์ โครงการพัฒนานโยบายด้านการสร้างเสริมสุขภาพและป้องกันโรค สำหรับเด็กโตและเยาวชน อายุ 6–25 ปี

วีรพงษ์ ทุมผล (2556) ความชุก และปัจจัยที่มีความสัมพันธ์กับภาวะโลหิตจางในนักเรียนมัธยมต้น จังหวัดจันทบุรี คณะสาธารณสุขศาสตร์ มหาวิทยาลัยมหิดล

แผนงานวิจัยนโยบายอาหารและโภชนาการ เพื่อการสร้างเสริมสุขภาพ (2557) รายงานสรุป การประชุมประจำปี แผนงานวิจัยนโยบายอาหารและโภชนาการ เพื่อการสร้างเสริมสุขภาพ ครั้งที่ 2 “การจัดการอาหารโรงเรียน”

ศูนย์เทคโนโลยีสารสนเทศและการสื่อสาร สำนักงานปลัดกระทรวงการพัฒนาสังคมและความมั่นคงของมนุษย์ (2558) ภาพการณ์ด้านสังคมระดับจังหวัด

ศูนย์เทคโนโลยีสารสนเทศและการสื่อสาร สำนักงานปลัดกระทรวง กระทรวงศึกษาธิการ (2557) สถิติการศึกษา ฉบับย่อ ปีการศึกษา 2556

ศูนย์วิจัยปัญหาสุรา สำนักงานพัฒนานโยบายสุขภาพระหว่างประเทศ กระทรวงสาธารณสุข (2556)

สถานการณ์การบริโภคเครื่องดื่มแอลกอฮอล์ และผลกระทบในประเทศไทย ปี 2556

สถาบันทดสอบการศึกษาแห่งชาติ (ไม่มีข้อมูล) รายงานประจำปี 2557

สำนักพัฒนาฐานข้อมูลและตัวชี้วัดภาวะสังคม สำนักงานคณะกรรมการพัฒนาการเศรษฐกิจและสังคมแห่งชาติ (2558) รายงานการวิเคราะห์

สถานการณ์ความยากจนและความเหลื่อมล้ำในประเทศไทย ปี 2556

สำนักงานคณะกรรมการพัฒนาการเศรษฐกิจและสังคมแห่งชาติ (2556) การคาดประมาณประชากรของประเทศไทย พ.ศ. 2553–2583

สำนักงานคณะกรรมการพัฒนาการเศรษฐกิจและสังคมแห่งชาติ (หลายฉบับ) ภาวะสังคมไทย (หลายฉบับ)

สำนักงานส่งเสริมสวัสดิภาพและพิทักษ์เด็ก เยาวชน ผู้ด้อยโอกาส และผู้สูงอายุ กระทรวงการพัฒนา สังคมและความมั่นคงของมนุษย์ (2556) รายงานการพัฒนาเด็กและเยาวชน ประจำปี 2556

สำนักงานส่งเสริมสวัสดิภาพและพิทักษ์เด็ก เยาวชน ผู้ด้อยโอกาส และผู้สูงอายุ

(สท.) กระทรวงการพัฒนาสังคมและความมั่นคงของมนุษย์ (255_) รายงานการพัฒนาเด็กและเยาวชน ประจำปี 2557

สำนักงานส่งเสริมสวัสดิภาพและพิทักษ์เด็ก เยาวชน ผู้สูงอายุ (สท.)

กระทรวงการพัฒนาสังคมและความมั่นคงของมนุษย์ (2550) พระราชบัญญัติ

ส่งเสริมการพัฒนาเด็กและเยาวชนแห่งชาติ พ.ศ. ๒๕๕๐ [National Child and Youth Development Promotion Act B.E. 2550 (2007)]

สำนักงานสถิติแห่งชาติ กระทรวงเทคโนโลยีสารสนเทศและสื่อสาร (2557) ตัวชี้วัดสำคัญทางด้านสังคม พ.ศ. 2557

สำนักงานสถิติแห่งชาติ กระทรวงเทคโนโลยีสารสนเทศและสื่อสาร (2558) ตัวชี้วัดสำคัญของประเทศไทย พ.ศ. 2558.

สำนักงานสถิติแห่งชาติ กระทรวงเทคโนโลยีสารสนเทศและสื่อสาร (2558) มอญจหวัดผ่านข้อมูลสถิติ พ.ศ. 2558.

สำนักงานสถิติแห่งชาติ กระทรวงเทคโนโลยีสารสนเทศและสื่อสาร (2558) วิเคราะห์เด็กและเยาวชน

สำนักงานสถิติแห่งชาติ กระทรวงเทคโนโลยีสารสนเทศและสื่อสาร (2558) สรุปผลที่สำคัญ

การสำรวจพฤติกรรมการสูบบุหรี่ และการดื่มสุราของประชากร พ.ศ. 2557

สำนักงานสำรวจสุขภาพประชาชนไทย สถาบันวิจัยระบบสาธารณสุข (2554) รายงานการสำรวจ การบริโภคอาหารของประชาชนไทย

สำนักงานสำรวจสุขภาพประชาชนไทย สถาบันวิจัยระบบสาธารณสุข (ไม่มีข้อมูล) รายงานการตรวจสุขภาพประชาชนไทย โดยการตรวจร่างกาย ครั้งที่ 4 พ.ศ. 2551–2

สำนักนโยบายและยุทธศาสตร์ สำนักงานปลัดกระทรวงสาธารณสุข (2558) สถิติสาธารณสุข พ.ศ. 2557

สำนักนโยบายและยุทธศาสตร์ สำนักงานปลัดกระทรวงสาธารณสุข (ไม่มีข้อมูล) สรุปสถิติที่สำคัญ พ.ศ. 2557

สำนักส่งเสริมและพัฒนาสุขภาพจิต กรมสุขภาพจิต กระทรวงสาธารณสุข (2558) คู่มือการส่งเสริมสุขภาพวัยรุ่นและเยาวชนในชุมชน

สำนักส่งเสริมสุขภาพ กรมอนามัย (2557) รายงานประจำปี 2556 สำนักส่งเสริมสุขภาพ กรมอนามัย

สำนักส่งเสริมสุขภาพ กรมอนามัย (2558) รายงานประจำปี 2557 สำนักส่งเสริมสุขภาพ กรมอนามัย

Annex I. Methodology

This study is the product of a literature review, scoping study, partner consultations, key informant interviews and group discussions.

Scoping study

In August 2015, a consultant was engaged to complete a literature review of key documents pertaining to adolescents in Thailand. The purpose of the scoping study was to determine study areas for exploration, and orient further data collection, analysis and reporting on the situation of adolescents in Thailand.

Desk review

A desk review was conducted after the scoping study to review national policy, relevant strategies and plans to identify opportunities and challenges in programming promoting and protecting the rights of the adolescent (survival, development, protection and participation).

Partner consultations

Consultations were organized with stakeholders from government departments, partner institutions, United Nations agencies and representatives from adolescent groups to identify:

1. main shortfalls and inequities in the achievement of adolescent rights;
2. bottlenecks and barriers and their causes; and
3. duty bearers and their roles in achieving a specific adolescent right.

Key informant interviews and group discussions

Key informant interviews were conducted with representatives from government agencies to gain an in-depth knowledge of adolescent related policies and programming, and the barriers and constraints in implementing these. Each key informant was contacted through email, telephone, and/or formal invitation letter to outline the focus of the interview. A total of six key informant interviews were conducted. Most organizations were represented by one or two staff members at the interviews, while a few agencies had three or more staff members present.

Three separate focus group discussions were held with MSM and transgender persons in Yangon, Mandalay and Patheingyi to gather vital background information on their needs and on the difficulties and challenges they had encountered. International NGOs providing drop-in centre services to MSM and transgender persons were asked to recruit between five and eight participants, either peer outreach workers or service users, for the focus group discussions.

As focus groups discussion participants arrived, they were welcomed and asked to review a consent form in Thai language, which explained the following:

- the purpose of the discussion and topics to be addressed;
- participation in the discussions was voluntary;
- they could leave at any time without any negative repercussions;
- a participant could refuse to answer any questions they did not feel comfortable answering;
- they could use nicknames or pseudonyms during the discussions;
- all discussions would be held in confidence and no names would be used in any reports;
- the group discussions would take approximately 90 minutes; and
- they should not discuss information shared by other participants during the focus group once they left the interview site.

The participants were asked to provide written consent, using a nickname or pseudonym or they could provide verbal consent if it made them feel more comfortable. When verbal consent was given, the discussion facilitator verified the consent by signing the consent form.

Each group discussion was carried out in a space that provided visual and auditory privacy from other adolescents not participating in the discussion and staff. A semi-structured discussion guide was developed by the consultants, who also facilitated the discussions. Notes were taken at each focus group discussion, trying to capture everything as accurately as possible. After each discussion, the notes were immediately reviewed and expanded as appropriate. Focus group discussions were conducted in Thai.

Limitations

Despite the comprehensive literature review conducted for the scoping study, much of the data collected was out of date due to the timing of the study. Many government agencies, such as the National Statistical Office, often release new reports before the end of the fiscal year, the end of September.

The recruitment of focus group discussion participants was arranged by government and non-government organizations providing adolescents in the Bangkok Metropolitan Area. It was not always possible for the agencies to recruit the desired number of participants (approximately eight persons) due to the scheduling of focus group discussions. In addition, representation of the broad diversity of adolescents was not achieved in these discussions. It was also not possible to conduct all the planned group discussions due to difficulties in recruiting adolescent participants.

Annex II. Stakeholders, key informants and discussion participants

Adolescent Expert Group Meeting, 1 October 2015

1. Assoc. Prof. Dr Suriyadeo Tripathi, MD	Director, National Institute on Child and Family Development, Mahidol University)
2. Wirote Areekul, MD	King Mongkut's Hospital, Royal College of Pediatricians, Association of Pediatricians
3. Kattiya Ratanadilok	Chief of Research and Development Sector, Department of Juvenile Observation and Protection, Ministry of Justice
4. Mathurada Suwannapho, MD	Director, Child and Adolescent Mental Health Rajanagarindra Institute, Department of Mental Health
5. Chatchawan Pantra	MOPH
6. Pawana Wienrawee	Path 2 Health - P2H
7. Assoc. Prof. Dr. Nunthavarn Vichit Vadakan	Founding Dean of Global Studies, Thammasat University
8. Dr. Bunyarit Sukrat	Bureau of Reproductive Health, MOPH
9. Devashish Dutta	Adolescent Advisor, UNICEF, EAPRO
10. Valerie Taton	Deputy Representative UNICEF Thailand
11. Beena Kuttiparambil	Chief, HIV/AIDS, UNICEF Thailand
12. Sirirath Chunnasart	Adolescent and HIV/AIDS Officer, UNICEF Thailand
13. Nalin Tantemsapya	Programme Assistant, UNICEF Thailand
14. Usasinee Rewthong	Consultant, UNICEF Thailand
15. Narat Punyacharoensin	Consultant, UNICEF Thailand
16. Patricia Chulamokha	Note Taker

HIV/AIDS Consultation for the Development of UNICEF Country Programme 2017–2021

1. Dr Taweessap Siraprasiri	Director, National AIDS Management Center (NAMC), Department of Disease Control
2. Dr Petchsri Sirinirund	Senior Advisor, Department of Disease Control, Ministry of Public Health
3. Dr Sumet Ongwandee	Director, Bureau of AIDS, TB and STIs, Department of Disease Control, Ministry of Public Health
4. Ms Surang Janyam,	Director of the Service Workers In Group (SWING)
5. Danai Linjongrat	Rainbow Sky Association of Thailand
6. Pinyapack Patana	Program Associate, Rainbow Sky Association of Thailand
7. Chaweewan Tonputsa	Public Health Technical Officer, Department of Health, Ministry of Public Health
8. Dr Suchada Chaivooth	Director, HIV and Tuberculosis Program, National Health Security Office
9. Dr Rangsim Lolekha	Thailand MOPH - U.S. CDC Collaboration, Ministry of Public Health
10. Chutima Saisaengchan	Project Manager, We Understand Group
11. Sunee Talawat	Raks Thai Foundation
12. Na Dew Law	Raks Thai Foundation
13. Piyawat Ketkrai	Raks Thai Foundation (Intern)
14. Vuthaya Charoenpol	Country Director, Peuan (Friends International)
15. Dr Nittaya Phanuphak	The Thai Red Cross AIDS Research Centre (TRCARC)
16. Wing-Sie Cheng	HIV/AIDS Advisor, UNICEF East Asia and Pacific Regional Office
17. Beena Kuttiparanbil	Chief, HIV/AIDS (Adolescent Development) Section, UNICEF Thailand
18. Sirirath Chunnasart	Adolescent and HIV/AIDS Officer
19. Shirley Mark Prabhu	HIV/AIDS specialist
20. Lori Thorell	ICT specialist
21. Narat Punpacharoensin	Adolescent SITAN consultant
22. Greg Carl	Adolescent SITAN consultant
23. Patricia Chulamokha	Rapporteur
24. Dr Chanuntorn Katasaene	Translator

HIV/AIDS and Adolescent Development National Consultation, 14 October, 2015 at Royal Princess Hotel on Lan Luang Road, Bangkok

1. Prakaidao Promprapat	Bureau of Reproductive Health
2. Tassana Suddeawkra	Division of Children and Youth Promotion Department of Children and Youth
3. Tappawan Pornwalai	Youth Expert Department of Children and Youth
4. Bhawinee Sumontree	Division of Children and Youth Promotion Department of Children and Youth
5. Raviwan Kaowanan	Director of Welfare and Development Division Department of Children and Youth
6. Dr Chosita Pavasuthipaisit	Child and Adolescent Mental Health Rajanagarindra Institute (CAMRI)
7. Nuchanart kaeodumkueng	Bureau of AIDS, TB and STIs, Department of Disease Control, Ministry of Public Health
8. Dr Kattiya Ratanadilok	Chief of Research and Development Sector, Department of Juvenile Observation and Protection
9. Piyarat Taimkhong	Department of Health, Bureau of Reproductive Health
10. Dr Wiwat Rojanapithayakorn,	Director Center for Health Policy and Management, Faculty of Medicine, Ramathibodi Hospital
11. Dr Jiraporn Arunakul	Faculty of Medicines, Ramathibodi Hospital
12. Pawana Wienrawee	Director, Path2Health foundation
13. Pornchai Srisoontornthai	Deputy Director, Path2Health
14. Dr Wadchara Pumpradit	Technical Advisor, Path2Health Foundation and Physician, Bamrungrad Hospital
15. Apiwat Kwangkaew	Chairperson, Thai Network of People Living with HIV/Aids (TNP+)
16. Brohmsek Yen-ura	Program Manager, Thai Business Coalition on AIDS (TBCA)
17. Wasurat Homsud	Operations Manager, Thai Business Coalition on AIDS (TBCA)
18. Chutima Saisaengchan	We Understand Group
19. Matana Bunnag	HIV/ADIS Manager, Plan Thailand
20. Yui Mutamol	Save the Children
21. Ticha Nopratkhet	Advocacy Officer, World Vision Foundation of Thailand
22. Chakkramong Chaiti	Youth Development Leader, World Vision Foundation of Thailand
23. Nutchawi Wadman	Programe Manager, Right to Play
24. Kittiphon Ditthabanjong	Youth Volunteer Group
25. Patama Deeklum	Youth Volunteer Group
26. Patcharapan Prajuablap	President, Youth Network of Bangkok
27. Keetapong Namwat	Deputy President, Youth Network of Bangkok
28. Parit Chiwarak	Education for Liberation of Siam
29. Pachoke Dechkamhang	Satriapsornsawan School
30. Sasitorn Phonsit	Satriapsornsawan School
31. Narong Fubprakhorn	President, Child and Youth Councils
32. Pongnarin Nonkam	Child and Youth Councils
33. Manatsporn Trongjitdilok	Phraharuthai Donmuang School
34. Tharit Promsurin	Phraharuthai Donmuang School
UNICEF	
35. Bijaya Rajbhandari	Representative
36. Valerie Taton	Deputy Representative
37. Devashish Dutta	Youth and Adolescent Development Specialist, EAPRO
38. Shirley Mark Prabhu	AIV/AIDS specialist EAPRO

39. Alistair Gretarsson	Chief Communication
40. Beena Kuttiparambil	Chief, HIV/AIDS (Adolescent Development)
41. Sirirath Chunnasart	Adolescent and HIV/AIDS Officer
42. Usasinee Rewthong	Comprehensive Sexuality Education Consultant
43. Michelle Schmit	Monitoring and Evaluation Specialist
44. Nantaporn Ieumwananonthachai	Child protection Officer
45. Nazia Ijaz	Corporate Alliance Specialist
46. Supavadee Chotikajan	Communication Officer
47. Napat Phisanbut	Communication Officer
48. Nalin Tantemsapya	Programme Assistant, HIV/AIDS (Adolescent Development Section)
49. Gregory Carl	Consultant, Adolescent SITAN
50. Narat Panyacharoensin	Consultant, Adolescent SITAN
51. Srinart King	Note taker

Key informants

1. Patchara Benjarattanaporn	UNAIDS
2. Dr Prawate Tantipiwatanaskul	Department of Mental Health (DMH)
3. Onchada Jiwhohoad	Office of the Vocational Education Commission (OVEC)
4. Tippawan Sutthikiri	Community Project Unit, Thai Red Cross AIDS Research Centre
5. Tasna Suddeawkrai	Division of Children and Youth Promotion, Department of Children and Youth (DCY)
6. Dr Kattiya Ratanadilok	Department of Juvenile Observation and Protection (DJOP)

Group discussions

Organization	Number of participants	Characteristics
1. Friends International	6 participants	Adolescents from a Thonburi congested community
2. Childline Thailand Foundation	5 participants	Adolescents attending drop-in centre services
3. Technical School, Pathum Thani	7 participants	Adolescents attending the vocational school

Annex III. Interview and discussion guides

Key informant interview guide

Topics and questions that were adapted for interviews with key informants from different agencies.

List 1

1. About this agency

- a. What are some of this agency's programmes and services for adolescents?
- b. What level of priority are each of these programmes and services given? (What programmes and services have the highest priority?)
- c. How are the programs prioritized? (epidemiology based-disease burden, demand driven, cost effectiveness)
- d. What policies and/or initiatives support these initiatives?

2. Scale of programmes and services

- a. Is the coverage/scale of programs and services sufficient to meet the need?
- b. With whom does this agency collaborate?
- c. In general, are budget allocations for adolescent mental programming and services sufficient?
 - How are adolescent mental health services funded? (ministerial, pooled funds between Ministries, public-private partnerships, other)
 - What are the trends in budgeting-increasing? Decreasing? Constant?
- d. What are the difficulties and limitations in rolling out programmes and services for adolescents, if any?

3. Capacity development

- a. How is the capacity of adolescent program implementers and service providers developed and sustained?
- b. What are the linkages with services for younger children and older adults?

4. About adolescent mental health concerns

- a. What do you see are the main mental health concerns among adolescents?
- b. What is the current situation of the concerns?
 - trends
 - severity
 - age group
- c. What are the major types of the issue?
- d. Are there any differences between...? Are data collected and disaggregated by:
 - age group
 - region
 - gender
- e. What are the key drivers of these concerns?

5. Adolescent participation

- a. How does this agency involve adolescents in the design, delivery and assessment of programmes and services?

6. Related to UNICEF

- a. What role could UNICEF play in adolescent mental health, well-being and development of adolescents from the perspective of this agency?
- b. Any other comments or suggestions?

List 2

1. About DCY

- a. What are this agency's key activities, programmes, and services for adolescents?
- b. Policies and legislations
- c. How does this agency approach adolescents?
- d. With whom does this agency collaborate (other agencies, NGO, other)?
- e. The limitations and difficulties in programming

2. About adolescent issues

- a. What do you see are the main issues among adolescents in your area of work?
- b. What is the current situation of the issues?
 - tendency
 - severity
 - age group
- c. What are the major types of the issue?
- d. Are there any differences between...?
 - age group
 - region
 - gender
- e. What are the key drivers of the issues?
- f. What are the programmes currently implemented?
- g. Any bottlenecks and barriers?

3. About adolescent participation

- a. What are the opportunities for adolescents to participate and contribute to the policy, programme and major decision-making process for adolescent development in the country?
- b. What are the networks and platforms for adolescent participation and development in the country?
- c. What are the process for considering requests and comments from child and youth council?
- d. How the committees are selected and the representativeness of the council?
- e. Any bottlenecks and barriers?

4. Related to UNICEF

- a. What are possible roles that UNICEF could play in adolescent development and programming?
- b. Any concerns, comments, and recommendations?

Group discussion guide

The following is a list of general questions that was adapted for each specific group of adolescents met.

1. Development

- a. What do you think has changed in your life compared with ten years ago?
 - i. Thoughts, emotions
 - ii. Confidence in making decisions, or scared of making bad decisions?
 - iii. Closeness to parents or adults; discussing problems with parents; do parents and adults have enough time for adolescents?
- b. What additional duties have you been given since you were younger?
- c. How do you think of your self, as an adult or still as a child?
- d. How do you think others see you?
- e. How well do adults understand adolescents?

2. Problems adolescents face

- a. How safe do adolescents feel these days?
- b. What makes adolescents feel scared?
- c. What risks do adolescents take?
- d. What do you think is the biggest problems that adolescents or your friends face?
 - i. What are the negative consequences?
 - ii. What is the cause of the problems?
 - iii. If a problem occurs, how do you solve it?
 - iv. Who do you discuss problems with?
 - v. Do you believe them/not believe them? Why?
 - vi. What can make this problem get smaller or be solved?

3. Adolescent services

- a. Who do adolescents talk to when they would like to discuss a health or safety problem?
- b. What would you do next? Where would you go?
- c. How do adolescents feel when they used these services?
- d. To what extent do adolescents get what they need from the services?
- e. Are the services friendly to adolescents?
- f. What don't adolescents like about services and what would make them not want to use the service again?
- g. How appropriate are the service hours?
- h. What is the cost for services?
- i. What other services for adolescents do you know about?

4. Activities

- a. What do you usually do after class or on weekends?
- b. Do you have enough time do the things that interest you?
- c. Is there something that you would like to do but don't?
- d. What do you think is more important, interesting activities or studying? Why?
- e. What would you like to do for society or the country?

5. Media

- a. Where do adolescents like to gather/hang out?
- b. Who do adolescents idolize?
- c. Is there anybody you do not like?
- d. What type of media do you use the most?
- e. What channel and program do you watch the most on television?
- f. What social media applications do you use?
- g. What websites do you like to access?
- h. If you would like to know more about something, from where would you seek information? Why?

6. Participation

- a. What do you think is your level of participation in your family? in your community?
- b. When you have something to say, how much do you think adults listen?
- c. How would you like to participate in your family and community?
- d. What do you think can be done if you want society to listen to the needs of adolescents?

7. Other

- a. What are your inspiration or ideals?
- b. When you are finished with your education / as you get older, what would you like to do?
- c. When you have reached adulthood, how could you help adolescents?
- d. Is there anything else that you would like to talk about?

Annex IV. Overview of laws applicable to Thai children and adolescents

INTERNATIONAL AND DOMESTIC LEGAL FRAMEWORK FOR CHILD RIGHTS, WELFARE AND PROTECTION

United Nations Convention on the Rights of the Child	Acceded 1991	Reservation to Article 7 (rights to birth registration, name and nationality) lifted in 2010. Reservation to Article 22 (rights of refugee children) remains.
ILO Convention on the Worst Forms of Child Labour (No. 182)	Ratified 2001	
Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography	Ratified 2006	
Optional Protocol on the Involvement of Children in Armed Conflict	Ratified 2006	
ILO Convention on Minimum Age for Admission to Employment (No. 138)	Ratified 2004	
Hague Convention on the Civil Aspects of International Child Abduction	Ratified 2002	
Optional Protocol to the Convention on the Rights of the Child on a communications procedure	Ratified 2012	
Prevention and Suppression of Prostitution Act	1996	Section 9 stipulates the penalty for engagement of a child younger than 18 years in prostitution.
Constitution of the Kingdom of Thailand	2007	Section 40 states that all children, young people, women and others (such as the elderly and disabled people) have the right to appropriate protection in judicial process and have the right to appropriate treatment in case relating to sexual offences. Article 51 of the 2007 Constitution states: [All persons] shall enjoy an equal right to receive proper and standard public health service, and he indigent shall have the right to receive free medical treatment from public health centres of the State ... A person shall have the right to receive proper prevention and eradication of harmful contagious diseases without charge in a timely manner. ²³⁶ Section 52 states that children, young people, women and families have the right to be protected by the State against violence and unfair treatment and have the right to medical treatment or rehabilitation. 'every person is equally entitled to the right to receive at least twelve years of a quality education provided by the government at no cost'.
Labour Protection Act	1998	Section 44 states that a child younger than 15 years may not be employed, while section 45 states the administrative procedures for a child younger than 18. Section 49 provides a list of hazardous work that children younger than 18 may not be employed to conduct.
Decentralization Act	1999	Section 16 of Chapter 2 mandates that TAO are responsible for provision of public services. Section 17 highlights the importance of social welfare and improving the quality of life of children, women, older persons and disadvantaged persons.
Child Protection Act	2003	Defines a series of welfare services and procedures for children at risk of abuse, violence, neglect and exploitation. The Act covers all children younger than 18 years and defines a wide range of categories of children who might be provided support under the Act, including children in conflict with the law, children at risk of abuse and exploitation, children in a range of institutions, and disabled children. Through omission, it appears that the Act applies to all children in Thailand, regardless of nationality. The services described within the Act are explicitly grounded in child rights principles of i) the best interest of the child and ii) non-discrimination. ²³⁷

²³⁶ Constitution of the Kingdom of Thailand, 2007.

INTERNATIONAL AND DOMESTIC LEGAL FRAMEWORK FOR CHILD RIGHTS, WELFARE AND PROTECTION

Civil Code	Amended in 2008	The Civil Code entered into force in 1925 and was most recently amended in 2008. Book 4, Title 2 addresses issues related to parents and children, including the rights and duties of the parent and child (Chapter II), guardianship (Chapter III) and adoption (Chapter IV).
Act on Juvenile and Family Court Procedure	2010	Establishes the regulations and procedures pertaining to children (younger than 15 years) and juveniles (younger than 18 years) who are in conflict with the law. The Act governs: criminal investigation procedures; the creation, functioning and powers of the Juvenile and Family Court; and the court orders that may be made to detain or refer children and young people to specific rehabilitation facilities. These facilities include: Juvenile Observation and Protection Centres; Training Centres; and Psychological Advisory Services.
Social Welfare Promotion Act	2003	Contains provisions for social welfare arrangements concerning social services, education, health care, housing, occupational training, recreational activities and criminal justice, by means of promotion and development of welfare, protection, prevention, correction and rehabilitation. Amended in 2007 to promote organizations in the civil sector to be more effective and responsive to the needs of the members, to install a system of 'mutual care and assistance' in communities, and to support networking in community social welfare arrangement in order to strengthen social security and promote self-reliance in communities.
Criminal Code	Amended 2003	Section 277 states that sexual intercourse with a girl under the age of 15 – regardless of consent – will be punished by a prison term of between 4 and 20 years as well as a fine. The penalty is more severe if the girl is younger than 13. Section 279 further stipulates a maximum penalty of ten years' imprisonment for a person who commits indecent acts on a child. Section 306 stipulates the punishment for abandonment of a child younger than 9 years. However, these more severe penalties do not seem to be aligned to the penalties stated in the Child Protection Act (Article 78) which provides that a person who commits acts against a child under Article 26 which amount to torture, exploitation, neglect, forced begging and labour (among others) 'shall be liable to a term of imprisonment not exceeding three months or a fine not exceeding 30,000 Baht, or both'.
Protection of Domestic Violence Victims Act	2007	Article 3 states that domestic violence pertains to any physical or mental violence perpetrated by a family member to anyone else living in the same household. As defined elsewhere in the Act this includes children living in the household.
National Policy, Strategy, and Measures for the Prevention and Suppression of Trafficking in Persons	2011–2016	Contains five strategies that are operationalised in annual action plans. Strategies include prevention, prosecution, protection and assistance, development of policy and promotion mechanisms, and development and management of information.
Children and Youth Development Act	2007	Establishes several provisions to strengthen institutions for the development of children (younger than 18 years) and youth (18–25 years). In particular, the Act focuses on ensuring the realisation of child rights and promotion of participation in development activities. For example, the Act reaffirms the right of children to education, healthcare, leisure, and birth registration in accordance with the Convention on the Rights of the Child. Similarly, the Act guarantees the same principles of best interests, non-discrimination and participation as the CRC to achieve these development outcomes.
National Health Act	2007	Article 6 stipulates that the health of women, children and people with disabilities and other specific health characteristics is to be promoted and protected appropriately.
Anti-Trafficking in Persons Act	2008	Section 6 (2) describes trafficking of a child as including the following actions: procuring, buying, selling, vending, bringing from or sending to, detaining or confining, harbouring, or receiving a child...[for the purpose of exploitation]. Section 4 describes the definition of exploitation to include: forced begging and labour; sexual exploitation, pornography and prostitution; and organ removal. Section 33 delineates the responsibility of the Ministry of Social Development and Human Security to provide assistance (such as medical, shelter, financial, education, repatriation) according and appropriate to the age of the person.

INTERNATIONAL AND DOMESTIC LEGAL FRAMEWORK FOR CHILD RIGHTS, WELFARE AND PROTECTION

Adoption Act	2010	Regulates the adoption of children in Thailand, including penalties for non-compliance with the Act's provisions.
National Policy and Strategic Plan on Sexual and Reproductive Health Development	2010–2014	The plan pays particular attention to increasing the availability and quality of SRH services that effectively reach most-at-risk adolescents. The goal of 80% of hospitals at all levels providing youth-targeted and youth-friendly reproductive health services was set in the plan, which aims to develop the capacity of hospitals, schools, and relevant agencies to provide quality SRH services. ²³⁸
Thai Medical Council Regulations	2012	Allows adolescents to test for HIV without parental consent as long as counselling is provided. However, consent from parents is still required for providing medical treatment.
National AIDS Strategy	2012–2016	Includes a specific objective relating to youth and commits to reviewing laws and policies to promote access to services. The Strategy requires creation of a system of integrated, youth-friendly services for in and out-of-school youth in the areas of reproductive health, adolescent health, sexual health, and HIV in ways that are participatory and youth strengthening. ²³⁹
National Plan of Action for a World Fit for Children	2007–2016	Focuses on children younger than 18 years. The plan promotes child and adolescent physical and mental health through knowledge and skills development, reproductive health, family education and sex education, and improved access to services. ²⁴⁰
National Plan of Action to Eliminate the Worst Forms of Child Labour	2009–2014	Aims to prevent, protect, and withdraw children from the worst forms of child labour, improve legislation and law enforcement related to the worst forms of child labour, and build the capacity of officials who administer policies and programs on the worst forms of child labour.

²³⁸ UNESCO, 2013, p. 67.

²³⁹ Thailand National AIDS Committee, *National AIDS Strategy 2012–2016, In brief*, 2012, p. 16.

²⁴⁰ National Commission on the Promotion of Child and Youth Development, *National Child and Youth Development Plan 2012–2016*, 2012.



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